

DOCTORAL THESIS

Counselling psychologists' talk about the diagnosis of 'Schizophrenia'

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**COUNSELLING PSYCHOLOGISTS' TALK ABOUT THE DIAGNOSIS OF
'SCHIZOPHRENIA'**

by

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Abstract

This research explores how counselling psychologists construct of the diagnosis of ‘schizophrenia’ and their perceived ability to work with this client group. The diagnosis of ‘schizophrenia’ does not feature prominently in counselling psychology literature, and there is a distinct lack of empirical research pertaining to how counselling psychologist construct this diagnosis, as well as accounts of their experiences of working with this client group. The literature review commences with: an exploration of the context of counselling psychology with particular reference to theory, practice and research; the diagnosis of ‘schizophrenia’ in relation to the medical model debate; and, the implications of ‘schizophrenia’ for the theory and practice of counselling psychology, with a particular reference to diagnostic categories. A version of discourse analysis known as ‘critical discursive psychology’ is used to analyse how eight counselling psychologists talk about and around the diagnosis of ‘schizophrenia’ in semi-structured interviews. The analysis demonstrated a number of repertoires used in relation to the diagnosis of ‘schizophrenia’ and how these counselling psychologists use them in different ways. The analysis suggested that through the use of these repertoires the counselling psychologists negotiated their relationship with their clients, their ‘identity’ as counselling psychologists and the organisations they worked for. It was also found that there were a number of difficulties in their relation to the diagnosis of ‘schizophrenia’, such as how to negotiate the balance between phenomenology and empiricism, as well as the sometimes detrimental effects the institution had on the counselling psychologists. The research also raised questions concerning methodology and the use of critical discursive psychology in studying this topic, as well as issues regarding the conflicting epistemological positions of counselling psychology and critical discursive psychology.

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1. Preface

1.1 Introducing the Author

My path into counselling psychology followed the typical route of studying psychology at university in the United Kingdom in order to gain Graduate Basis for Chartership (GBC), and thereafter spending three years acquiring experience working as a recovery worker at a secondary care residential and rehabilitation unit in the National Health Service, hereafter NHS. This rehabilitation unit had as its aim the integration of individuals diagnosed¹ with ‘schizophrenia’² into the community after long spells in hospital following sectioning and admittance to a psychiatric unit. Many of the clients I worked with were so called ‘revolving door’ clients (e.g. Glazer & Ereshefsky, 1996), who had spent years moving in and out of different levels of psychiatric care and whose pattern of detainment and rehabilitation usually followed: i) sectioning under section 2 (compulsory admission to hospital for assessment for a maximum of 28 days) or section 3 (compulsory admission to hospital for treatment for a maximum of six months, with the possibility of extending for an additional six months) (see Department of Health, 1983); ii) long-term stay in psychiatric hospital for ‘stabilisation’ using antipsychotic medication; iii) discharge to community rehabilitation team for two to three years; iv) discharge to independent community living , or discharge to community residential and rehabilitation team; iv) discharge into independent community living after two to three years of ‘rehabilitation’; v) relapse and admitted to hospital. Then the process would start again. Seeing this happen to different individuals at

¹ The term *individual(s) diagnosed with ‘schizophrenia’* will be used in this research in order to avoid using terms like *schizophrenic* or *schizophrenia-sufferer*, which are deemed to be stigmatising and pejorative (e.g. Haghighat, 2008).

² Inverted commas will be used throughout the research to signify constructed ideas and bring taken for granted concepts into question.

different stage of their 'treatment' placed me in a position to start thinking critically about individuals diagnosed with 'schizophrenia' and the care they were offered. Psychological therapies were not considered appropriate for this client group and the majority of the clients' time was spent smoking in common rooms, rather than being engaged in 'rehabilitation'. Although staff did try, the fact that they were under-supported and under-supervised made working with individuals who had 'psychotic' presentations difficult at times. This made me wonder about the provision of psychological therapies, or rather the lack of, in the NHS and what it was that was keeping this from being established in the trust I worked for (it is worth noting that by writing these words I am positioning myself as an individual that believes that psychological therapy would be beneficial to individuals diagnosed with 'schizophrenia' rather than not). I regularly attended meetings where research proposals from trainee clinical psychologists and other members of mental health teams in the service were considered and implemented in the trust. A colleague and I presented a proposal to see if we could explore the possibility of setting up an evaluation to gauge clients' views of psychological therapies, and if such a service *did* exist, would they use it. This proposal was not met with particular interest by the research team so there was a direct feeling of discouragement in pursuing this line of research. Parker and colleagues (1995) stated that 'generic mental health workers', who are considered 'outside the pathologizing disciplines' (p.54), had the opportunity to challenge those in more 'professionally' regulated careers about notions of power and professionalism. Although this rang true to an extent, because of the political context this is sometimes difficult in practice.

The failure of our presentation to the research board led me to an interest in counselling psychology and the possibility of providing psychological therapies for individuals diagnosed with 'schizophrenia'. When starting my counselling psychology

training I thought naïvely perhaps, that this would be a possibility, but again came up against some resistance regarding counselling psychologists working with this client group. The positive aspect of my training was that the critical slant the department took allowed me to develop my thinking around the topic and therefore develop my research in this area. While I hoped that this research may work to raise some awareness about counselling psychology's role in working with individuals diagnosed with 'schizophrenia', it is still understood that there are barriers to psychological therapies for this client group, and that as a group they remain marginalised.

1.2 Introducing the Research

This research thus provided me with an opportunity to explore an area which related to my personal and clinical interest regarding the empowerment of marginalised individuals, while also trying to problematise the same sense of marginalisation through the profession of counselling psychology. The standard of 'care' offered to clients diagnosed with 'schizophrenia', which largely consisted of pharmacological maintenance and only intermittent psychological input, made me wonder what counselling psychologists could offer this client group. It became apparent upon further research that counselling psychology as a profession has never overtly been involved in working with individuals diagnosed with 'schizophrenia', which again made me ask why this is the case. So the idea was to explore what possibilities could be made for counselling psychologists in working with individuals diagnosed with 'schizophrenia', as well as how to provide access to a service which this client group repeatedly asks for but never receives. Perhaps one of the most striking questions was, if individuals diagnosed with 'schizophrenia' who are in the mental health system repeatedly state that the therapeutic relationship is a vital aspect of their recovery, and

if counselling psychologists profess to offer the therapeutic relationship as one of their defining professional values, what is it that keeps them from working with each other?

Reflexive Summary 1: Reflexive Summaries

Burr (2003) argued that discourse analysts must find a way of incorporating their own accounts into the research. So by attempting to contextualise the research idea and its development, as well as the progress of the research process itself we might be able to see how to make an account more accountable, not just through an ‘agonising confession’, as argued by Harper (1999) and Parker (1999a) or a self-referential solipsism as argued by Burman (1991), but through an attempt to explicate the interests and other forces at work in the production of the account. As argued by Kidder and Fine (1997), subjectivities must be ‘acknowledged, studied, interrogated and written about’ (p.40). By attempting this, the author is aiming to transform subjectivity in research from a potential problem to an opportunity (Finlay, 2002a). In order to demonstrate the reflexive element of the research, and to make it an integral part of the research itself (Mantzoukas, 2005), reflexive summaries will be included in boxes such as this one to highlight the development and the process of the research as well as to raise some of the conceptual and methodological difficulties that were encountered throughout the process. This strategy has been employed elsewhere by Harper (1999) and Perry (2007). It is the researcher’s intentions to not let these reflexive summaries interfere with the flow of the main body of the research and therefore distract the reader from the content, which is of equal importance to the reflexive element. One could argue that the reflexive accounts would have been more appropriately placed within the appendix, however, this might have ‘removed’ or de-contextualised the

reflexive element and therefore turned in into an ‘after thought’ when it should be considered a part of the research body itself.

For example, in accounting for the positions taken above, Wilkinson (1988) identified three forms of reflexivity, of which two will be accounted for in this summary: *personal* (i.e. issues surrounding the identity of the researcher) and *disciplinary* (i.e. the nature of or the influence of the field of inquiry).

Personal

Breuer (2000) identified a multitude of reasons that may draw researchers towards particular research topics, including: elements of intellectual and emotional comfort, individual interest in a certain phenomenon and an attraction toward certain roles or environments that complement individual style. Having worked with individuals with a diagnosis of ‘schizophrenia’ in an NHS secondary care setting for a number of years before pursuing the practitioner doctorate in counselling psychology, I entered the research field knowing that my interests lie in exploring counselling psychology and ‘schizophrenia’ in some way. This might be considered a more biographical influence (Harper, 1999), whereby my background set the foundation to build upon with further research. The context of the training itself was also a factor, as I gained an appreciation of and identification with postmodern and social constructionist approaches to counselling (e.g. Hansen, 2004, 2006) and more critical approaches to psychology and psychopathology (e.g. Parker *et al.*, 1995; Fox & Prilleltensky, 1997; Thomas & Bracken, 2004) through counselling psychology’s ‘professional philosophy’ of non-pathologizing (Lane & Corrie, 2006), which produced an environment that was conducive to critical research. This

provided the incentive to explore a taken for granted concept, such as the diagnosis of ‘schizophrenia’, through the lens of a profession who by their own admission do not usually work with this client group.

Disciplinary

However, it was also within this context that I became more thoughtful of counselling psychology’s conflicted epistemological position (Williams & Irving, 1996) and developed an increasingly questioning attitude towards what counselling psychology actually *is*.

Before arriving at that stage the idea went through a series of revisions, beginning with a desire to explore the possibility of counselling psychologists working relationally with individuals with a diagnosis of ‘schizophrenia’, and examining the development of the therapeutic relationship (e.g. Frank & Gunderson, 1990; Johansson & Eklund, 2003; Bentall *et al.*, 2003; Hewitt & Coffey, 2005). The second idea was to attempt to explore how, if at all, counselling psychologists could work within the client’s ‘own frame of reference’. In other words, trying to explore how counselling psychologists might try and make sense of the ‘schizophrenic’ experience, and if their ‘relational’ approach might help in working with the client’s subjectivity as opposed to imposing a therapeutic technique (e.g. Strauss, 1989; Geekie, 2004; Knight, 2005; Geekie & Read, 2009). This idea then gave way to look at counselling psychologists’ experiences of working with individuals with a diagnosis of ‘schizophrenia’. However, due to potential time constraints and the difficulties of obtaining NHS ethics approval, as well as the possibility of not actually finding counselling psychologists who have worked with individuals with a diagnosis of ‘schizophrenia’ in the NHS, this idea was abandoned in order to look at counselling psychologists’ views on the diagnosis of ‘schizophrenia’. This offered a ‘back to basics’

approach, but one which had the potential to provide depth to the research and a topic which had not yet been explored. It was this move that also set me towards using discourse analysis as a methodological consideration.

2. Introduction

'They called me mad, and I called them mad, and damn them, they outvoted me' - Nathaniel Lee, English playwright, on being committed to the Bethlehem 'Bedlam' Hospital in 1684
(cited in Porter, 2003)

'There is no such 'condition' as 'schizophrenia', but the label is a social fact and the social fact a political event' (Laing, 1990b: 100)

Although Lee and Laing uttered these statements almost three centuries apart (*The Politics of Experience and The Bird of Paradise* was originally published in 1967), what they had to say then echoes today. One could argue that both individuals were referring to the constructed nature of 'madness' and how it functions within particular domains; Lee in the sense that the definition of 'madness' is generated through social consensus, and Laing through stating that the existence of 'schizophrenia' is a social phenomenon rather than a 'condition', which as a social phenomenon has political ramifications. This research is concerned with such constructions, and more specifically the construction of 'schizophrenia'. The word 'schizophrenia' evokes a variety of feelings and images; some picture it as the 'holy grail' of their profession (Grob, 1998), others imagine violence and feel fear (Levey & Howells, 1994) and react by discriminating against it (Dickerson *et al.*, 2002), and some view the word as a signifier of prophecy (Siirala, 1961), existentialism (Laing, 1990a) or spiritual meaning (Chadwick, 2007), to name but a few. Going by the assortment of positions the word 'schizophrenia' conjures up, it could be safe to follow the hermeneutical assertion that there are as many 'schizophrenias' as there are readers; however, it has been argued that the dominant 'reading' of 'schizophrenia' today is the bio-medical one (Boyle, 2005). This

interpretative aspect of the diagnosis of 'schizophrenia' is of particular interest to this research, which will aim to explore this from the position of counselling psychologists. For whatever associations are made with the word 'schizophrenia', the image of counselling psychologists is not one of the more prominent. As will be outlined in this research, counselling psychology lacks a history alongside the diagnosis of 'schizophrenia'; it does not regularly appear in textbooks on 'psychopathology' like psychiatry does, and it does not appear in the literature as one of the 'players' involved in the treatment of individuals diagnosed with 'schizophrenia', such as clinical psychology. There are, of course, accounts of 'psychotherapy' and in some cases 'counselling' being associated with the term, but rarely counselling psychology.

The research question concerns how counselling psychologists construct the diagnosis of 'schizophrenia' and how they view their ability of being able to work with this client group. To say that 'schizophrenia' is constructed is to say that the label itself is a discursive act that is historically and culturally specific (e.g. Burr, 2003). The research will employ a version of discourse analysis called 'critical discursive psychology', whereby the aim is not only to look at discursive factors and what implications these may have for counselling psychologists, but also at the extra-discursive factors available to counselling psychologists, such as the power of the institution they work for or their training organisation. This would suggest that counselling psychologists are both producers of discourse (i.e. they actively construct the diagnosis of 'schizophrenia') and subject to discourse (i.e. there are limits to how counselling psychologists can talk about the diagnosis of 'schizophrenia'). This has not yet been done in the counselling psychology literature, and it is hoped that this research will contribute to a neglected area in the field. The research will begin by presenting a literature review on counselling psychology and the diagnosis of 'schizophrenia'; it is hoped that the

review will aid in setting the ‘scene’ for the remainder of the research. The next two sections concern the methodology employed in the research and the difficulties encountered in attempting to locate what is the discursive and what is the extra-discursive, as well as the method and procedure that was followed in recruiting, interviewing and analysing the text gathered. After that will be an exploration of the ‘discourses’ located in the interviews (as interpreted by the author) and finally a discussion outlining the usefulness these findings may have for the profession of counselling psychology as well as the limitations of the research. Because of space limitations, the sections that follow are not exhaustive, nevertheless, it is hoped that the information provided in this research will be enough to generate further questions and discussion surrounding the topic.

Finally, it is worth noting that since this research takes a constructionist view as its epistemology, this introduction itself is a construction and so is all the material that follows; Perry (2007) referred to this as ‘constructing a constructionist introduction’ (p.150). So it is important to remember that what is presented in this research is not a ‘truth’ about the research topic, but should instead be considered a construction relevant to the research foci, and that by being presented as such the material works towards positing and legitimating a particular version of events (Craven & Coyle, 2007).

3. Literature Review

3.1 Introduction

Counselling psychology's relationship with diagnostic categories such as 'schizophrenia' has received little attention in the literature. The majority of what one finds is constituted by theoretical debates and philosophical discussions. Additionally, a few descriptive studies have explored the views and use of diagnostic categories within counselling and psychotherapy, however, the descriptive literature as pertaining to counselling psychology remains scarce. This literature will be summarised here, with attention paid to existing epistemological and ontological arguments, as well as past and present thoughts on the matter. Due to the difficulties in providing a comprehensive review of such a broad subject, this review will attempt to capture the most salient issues, while at the same time providing a concise, integrated exploration. Further, while overlap may occur in some areas, generally the review will focus on the main question of interest, which specifically aims to examine the relationship between counselling psychology and the diagnostic category of 'schizophrenia', and how this relationship might affect a perceived ability of being able to work with individuals diagnosed under that category. As such, the review presents a brief historical context within which to situate current views. Following this, the review focuses on currently discussed areas of the relationship between counselling psychology and the diagnosis of 'schizophrenia', including the following: epistemology and ontology of counselling psychology; methodology and axiology in counselling psychology; the medical model debate; diagnostic categories; the diagnosis of 'schizophrenia'; and the relationship between theory and practice in counselling psychology. Next, the review will summarise the contextual factors believed to contribute to the use of diagnostic categories in the practice of counselling psychology, including: economic, social, political and linguistic.

Lastly, the review discusses the values of counselling psychology and shows that organisation of existing opinion, as well as more in-depth discussion about the relationship between counselling psychology and the diagnosis of 'schizophrenia' is needed. This review is important in order to 'set the scene' for the remainder of the research, which will focus on counselling psychologists' constructions of the diagnosis of 'schizophrenia' and their experiences of working with individuals diagnosed with 'schizophrenia'. The research will also aim to explore the institutional 'effects' on counselling psychologists, such as their place of work and training organisations. It is worth noting, however, that there may be some repetition in the material as there is a difficulty in speaking about one topic without including another.

3.2 Literature Search

Using *PsycARTICLES* and *PsycINFO* to search for *counselling psychology* and *schizophrenia* resulted in six results; searching for *counseling psychology* (American spelling) and *schizophrenia* resulted in 17 results. Using a more specific search to target journals specific to counselling psychology yielded varying results: *British Journal of Guidance and Counselling* (1973-present) 27; *Counselling and Psychotherapy Research* (2001-present) 27; *The Counseling Psychologist* (1969-present) 35; *Counselling Psychology Quarterly* (1988-present) 793; *Counselling Psychology Review* (2004-2007) 3; *European Journal of Psychotherapy and Counselling* (formerly *European Journal of Psychotherapy, Counselling and Health*) (1998-2006/2006- Present) 31; *Journal of Counseling Psychology* (1954-present) 14; *Psychology and Psychotherapy: Theory, Research and Practice* (formerly *British Journal of Medical Psychology*) (1999-2001/2002-present) 0; and, *Psychotherapy Research* (1991-present) 33.

These results indicate an extremely low presence of counselling psychology literature relating to the diagnosis of ‘schizophrenia’, with the most skewed result being *Counselling Psychology Quarterly* with 793 results. However, if searching for ‘schizophrenia’ again within the returned results from *Counselling Psychology Quarterly* one is presented with only three results that directly link counselling psychology with ‘schizophrenia’ and that explore narrative impoverishment in ‘schizophrenia’ (Lysaker & Lysaker, 2006), parental responses to children diagnosed with ‘schizophrenia’ (Osborne & Coyle, 2002) and a literature review on coping strategies for auditory hallucinations (Knudson & Coyle, 1999).

3.3 The Context of Counselling Psychology

This section intends to provide a brief outline of counselling psychology and how it is situated historically. Even though the task of situating counselling psychology professionally and intellectually is inevitably complex (Strawbridge & Woolfe, 2010), it is hoped that this section will provide a ‘picture’ of its development as a profession.

3.3.1 Brief History

Psychology emerged as distinct discipline throughout the 1800s. During this time psychologists adopted the scientific and philosophical foundations of the time, and ‘mental illnesses’ were treated with a variety of approaches that were said by some to be ‘scientific’ and ‘effective’ (see Richards, 2002 for a review). The treatment of the ‘mentally ill’ began in the institutions, and it was not until Freud advocated what became known as talking therapy in the form of psychoanalysis that care administered in hospitals and other institutions shifted to home-based treatment (Cohen, 1993). Decades later behaviourism would follow psychoanalysis as the next treatment for psychological disorders, based on the reductionist, deterministic theories of Watson, Skinner and their contemporaries (Wampold, 2001b). By

the 1950s, the influence of dynamic, humanistic, and other theories led many psychotherapists to abandon what was known as the medical model ideology and seek new, psychosocial understandings of mental problems. The medical model argues that mental disorders are natural kinds and through empirical research their respective aetiologies can be identified and ascribed pharmacological interventions (Cosgrove, 2005). Rogers was one of the founders of what was to become the humanistic movement, which opposed the ideas of psychoanalysis, behaviourism and medicalisation by emphasising optimal functioning as opposed to pathology and a conceptualisation of the person as an individual ‘self’ (McLeod, 2003b). Strawbridge and Woolfe (2010) argued that counselling psychology developed from, and was inspired, by thinkers who understood the subjective world of the ‘self’ and other to be central in psychology. They also stated that counselling psychology has since developed into a:

‘broad church, committed to exploring a range of approaches to inquiry and recognizing the contribution of differing traditions in psychology, including: the phenomenological, (existential and humanistic); the psychoanalytic/psychodynamic; the cognitive-behavioural; and the strongly emerging and related constructionist, narrative and systemic traditions’ (p.4).

Counselling psychology has also developed differently depending on context, for example, in the United States of America it was initially influenced by vocational guidance and psychometrics (Munley *et al.*, 2004) rather than the ‘therapeutic’ role it took in the United Kingdom. As stated by Pelling (2004): ‘Counselling psychology is quite established in the USA, somewhat stable in the UK, less established in Canada, and has a fledgling existence in NZ. Australian counselling psychology is noted as struggling for recognition’

(p.240). Pelling argued that the counselling psychology in 'Western' countries all shared similarities and some differences, for example, some of the commonalities include a struggle for identity, a scientific focus and an honouring of diversity. The differences between them include training route, social and historical differences and a varying career focus (see Munley *et al.*, 2004 for a review of counselling psychology in the USA; Lalande, 2004 for Canada; Brown & Corne, 2004 for Australia; Stanley & Manthei, 2004 for New Zealand; and Walsh *et al.*, 2004 for the United Kingdom). Similarly, counselling psychology also has a presence in countries outside of the 'Western' sphere, including Hong Kong (Seay, 2010), Japan (Watanabe-Muraoka, 2007) and South Africa (Leach *et al.*, 2003), which in turn have particular contextual influences that need to be considered in their historical development (Orlans & van Scoyoc, 2009).

Counselling psychology emerged as a distinct profession in the United Kingdom during the 1990s, and in 1994 was officially recognised by the British Psychological Society, hereafter BPS, as having a unique identity and philosophy of practice (Corrie & Callahan, 2000). As defined by the BPS's *Division of Counselling Psychology Professional Practice Guidelines* (2006b), counselling psychology emphasises a 'value base grounded in the primacy of the counselling or psychotherapeutic relationship', and within this suggests that we are 'not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing' and will 'challenge the views of people who pathologise on the basis of such aspects as sexual orientation, disability, class origin or racial identity and religious and spiritual views'. Not assuming one way of knowing has led to counselling psychology being influenced by a variety of epistemological positions, including the scientist-practitioner model, reflective-practitioner-model, humanistic values as well as post-structuralism and postmodernism (e.g. Strawbridge & Woolfe, 2010). Counselling psychology differed from

psychotherapy (Jacobs, 2000) and counselling (Dryden *et al.*, 2000) by accreditation route and professional practice being grounded in the scientist-practitioner model (Lane & Corrie, 2006), as well as by placing an emphasis on psychology as the knowledge base of the discipline (Barkham, 1990). However, as outlined by Orlans and van Scoyoc (2009), this grounding in psychology has caused difficulties for counselling psychology as psychology's positivist knowledge base and conception of 'science' has in some ways clashed with the humanistic values adopted by counselling psychology as a philosophical value base. The humanistic values mentioned above see the core uniqueness of counselling psychology as having a 'respect for the personal, subjective experience of the client over and above notions of diagnosis, assessment and treatment, as well as the pursuit of innovative, phenomenological methods for understanding human experience' (Lane & Corrie, 2006: 17). Grounded in humanism's philosophy of non-pathologising, or a reluctance to use labels to describe client difficulties, and the uniqueness of each individual and their self-actualising tendencies, counselling psychology became a part of the 'third force' which aimed to challenge the prevailing orthodoxies of psychoanalysis and behaviourism (Rizq, 2008). With this philosophical position came an inherent objection to the medical model of psychology and the use of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (APA, 2000), hereafter DSM, as a means of pathologising clients' distress. Counselling psychology sought to distinguish itself from clinical psychology and other more well-established professional domains within psychology in order to legitimise itself as a unique domain of knowledge and practice (Pugh & Coyle, 2000). Other contentious issues (James & Bellamy, 2010) augmenting counselling psychology's professional positioning include the debate on evidence-based practice (Milton, 2003), the use of psychometric testing for assessment and the measurement of psychological problems (Kanellakis, 2003), the use of diagnostic categories to describe client difficulties

(Strawbridge & James, 2001; Turner-Young, 2003) and counselling psychology's interface with medical professions (Orlans & van Scoyoc, 2009).

In many of these debates, counselling psychology has attempted to construct a position on these issues that is distinctive to itself. However, this has raised some difficult questions for counselling psychology as it faces the reality of working in professional settings that are dominated by the medical model. As Bury and Strauss (2006) asked: how, if at all, can the use of diagnostic labels in practice be reconciled with counselling psychology's humanistic value base? How should counselling psychology position itself, as a profession, in relation to matters such as diagnosis, psychological testing and standardised approaches to 'treatment' delivery (Lane & Corrie, 2006)? Woolfe (1996) argued that the scientist-practitioner model was essential to the formation of the discipline: 'Counselling psychology, therefore, can be seen as located in a pivotal position between narrow scientism on the one hand and a failure to take sufficient account of a scientific method on the other' (p.11), and as Corrie and Callahan (2000) stated, if counselling psychology is to further develop within the NHS, it must embrace the ideology of 'evidence-based' practice and conform to the role of the scientist-practitioner model. However, some argue that the scientist-practitioner model cannot capture the essence of the therapeutic relationship that is integral to the work of counselling psychologists, and the model is in danger of driving counselling psychology towards the 'scientism' it aimed to challenge in the first place (Carter, 2002). With the NHS increasingly becoming a common source of employment for counselling psychologists (Bor & du Plessis, 1997), where psychiatric classification is the dominant language for discussing and thinking about an individual's difficulties (Golsworthy, 2004), counselling psychologists might find themselves in a position where they will have to adopt a medical discourse. Hage (2002) argues that the process of counselling psychologists moving away from focusing on

issues of health and adaptation and moving towards aetiology and pathology has already begun.

This process contributes to what has been called the ‘great psychotherapy debate’ (Wampold, 2001a) raging between the medical model and the contextual model, whereby the contextual model would aim to promote the demedicalisation of psychology while at the same time develop a suitable alternative (Pérez-Álvarez & García-Montes, 2007). As Golsworthy (2004) argued, this is an ongoing and timely debate within the profession of counselling psychology at a moment when psychological understanding and methods are beginning to have greater political recognition, and that a move towards the medical model could threaten the very attributes that make counselling psychology distinctive (Lane & Corrie, 2006). Golsworthy (2004) argued that counselling psychology is situated within a clash of culture with regard to the medical model; on the one hand, the *Division of Counselling Psychology Professional Practice Guidelines* (2006b) argues that counselling psychologists should not pathologise or discriminate in terms of behaviour, while at the same time engage in the language of the DSM, which assumes a set of normative behaviour. He argues that it is the counselling psychologist’s job to empower rather than to control, and in order to do this:

‘we need to take our educative role seriously: our clients have the right to be informed about powerful systems that affect the way their distress is conceptualised and the relationship of this to drug (and other) treatments. We can assist our clients in understanding the implications for them of diagnosis, allowing them to make decisions about their care from a position of knowledge’ (p.27).

As Rizq (2007) pointed out, this debate might seem like a ‘tired old dualism’; however, in the context of the philosophy of counselling psychology these questions are essential, for as Kinderman (2009) argued: ‘The future of counselling psychology relies on what perception is dominant’ (p.20). Woolfe’s argument about counselling psychology’s dichotomous position between empiricism and the phenomenological will be explored with regard to counselling psychology’s epistemological and ontological positions.

3.3.2 Epistemology and Ontology of Counselling Psychology

Epistemology is concerned with how we know what we know (Brown, 2002); an empiricist framework would assume a positivist and objectivist stance, while a phenomenological epistemology would argue for a subjectivist stance, maintaining that reality is socially constructed (Ponterotto, 2005). Williams and Irving (1996) argued that counselling psychology has a ‘conflicted conceptual framework’ (p.4), which is grounded in both a logical empiricist framework and a phenomenological one. This places counselling psychology between two different epistemological positions: one which would advocate the use of diagnostic categories such as ‘schizophrenia’, and another that would endeavour to understand clients in their own terms, without the use of labels; this appears to be an epistemological contradiction (e.g. Brown, 2002). An attempt to integrate these two stances results in what Williams and Irving (1996) called a ‘logical absurdity’ (p.6), however, this is what has been attempted by counselling psychology in both research and practice by adopting a scientist-practitioner model. This model was conceived as a marriage between therapeutic practice and scientific psychology at the Boulder conference, Colorado, in 1949. The scientist-practitioner model was intended to provide a framework for training and professional practice, particularly within the emerging field of clinical psychology (Corrie & Callahan, 2000) and aimed to serve the dual function of safeguarding the public against poor

practice and furnishing the profession with a clear identity and direction (Long & Hollin, 1997). With this model being adopted by a counselling psychology striving for professional identity (Lane & Corrie, 2006) it has come under attack as being untenable for the practice of counselling psychology, and that the different priorities of 'scientist' and 'practitioner' leads to an insurmountable rift between activity and function (Williams & Irving, 1996; Rennie, 1994). Particularly within counselling psychology, the appropriateness of trying to integrate research and practice within a single training model has been questioned, and appears to directly contradict the notion of counselling psychology privileging the 'respect for the personal, subjective experience of the client over and above notions of diagnosis, assessment and treatment, as well as the pursuit of innovative, phenomenological methods for understanding human experience' (Lane & Corrie, 2006: 17). As van Deurzen-Smith (1990) argued, the very philosophical underpinnings of counselling psychology emerged in a response to a psychology that was too preoccupied with scientism to be able to inform our understanding of the dilemmas of human existence.

This crisis of rationality emerged from methodology, which refers to the process and procedures of research (Ponterotto, 2005), whereby the quantitative paradigm was seen as being problematic in its attempts to 'discover' a reality independent of an observer's cultural and social context (Corrie & Callahan, 2000), and gave way to a fundamental re-examination of what constitutes human reality and the methods best suited to its investigation. Two principal meta-theoretical responses to this crisis came in the form of social constructionism and critical realism. Burr (1995) argued that social constructionism emerged from a number of sources, and can be divided into several types, including: critical psychology, which sees social constructionism as a form of social critique; discursive psychology, which focus on social interaction and language as a form of social action, that was developed by Potter and

Wetherell (1987); and deconstructionism, postmodern and post-structuralist philosophies, including the works of Foucault (1976) and Derrida (1990), which rejects the belief that there are ultimate truths that can be discovered through observation and experimentation. Instead, knowledge is regarded to consist of multiple realities that are constructed within historically and culturally specific situations, with the realities being mediated through social interactions and language in particular, which is regarded as the vehicle through which meaning about oneself and the world is created. Therefore, language is not seen as truth bearing (Gergen, 2001b) but instead is seen as an object of study in itself, and that the discourse it generates is the only valid framework for investigating human experience (Gergen, 1985). Relativists refuse to accept a 'bottom line, a bedrock of reality that places limits on what may be treated as epistemologically constructed or deconstructible' (Edwards *et al.*, 1995: 26). By using references to 'death and furniture' (i.e. physical and material realities), Edwards and colleagues present a discourse analytic examination of realist arguments in order to demonstrate that even those references are themselves discursive constructions rhetorically deployed in the course of a debate. They argue that even thumping a table to appeal to its materiality is a semiotically mediated communicative act and, therefore, a discursive move. Tables can be described in different ways, for different purposes. We may refer to their uses, to their status as a cultural artefact, to the materials they are made of, their consistency at a molecular or even atomic level, and so on; hitting the table does not give it an extra-discursive position. Similarly, they point out that death can take many forms (e.g. natural death, terminal disease, murder, manslaughter, capital punishment, fatal accident, suicide, etc.) and it can be conceptualised in different ways (resurrection, afterlife, brain death, spiritual death, etc.). In this way, the authors reinforce their claim that 'it is language itself that provides the tools for constructing a reality beyond words' (p.31). However, to counter the often relativist consequences of applying social constructionism to psychological theory

(Parker, 1999c), Bhaskar (1975) and Manicas and Secord (1983) advocated a critical realist position. Critical realism argues for the recognition ‘that there are enduring structures and generative mechanisms underlying and producing observable phenomena and events’ (Bhaskar, 1989: 2). While relativism reduces psychological theories to stories about the mind where there is no inherent reality except for what is constructed (Ponterotto, 2005), Parker (1999a) suggests that there is a reality, but that it is a reality that can only be imperfectly understood (Ponterotto, 2005) and which possesses ‘enduring structures and generative mechanisms’ by which to engage critically. A particularly pertinent example is the use of diagnostic categories and how they are grounded within the ‘psy-complex’ (Parker, 1999b); this refers to the intricate network of theories and practices of academic and professional psychology that come to inform our most basic and everyday notions of self, mind, deviance and normality (Hook & Parker, 2002). Nightingale (2004) explored depression using a critical approach and argued for the inclusion of embodiment and materiality in its account without resorting to bio-medical pathology. These different epistemological frameworks offer what has been called ‘equally legitimate but incompatible world views’ (Dougher, 1995: 215), and are important to the theory and practice of counselling psychology as they are believed to constitute core beliefs about the fundamental nature of the world and what constitutes the basic objectives of science (Brown, 2002).

Ontology concerns the nature of reality and being (Ponterotto, 2005), and more specifically addresses the question: What is the form and nature of reality and what can be known about that reality? Yancher and Hill (2003) argued that the ontology of psychology is problematic as a whole, and has its origins in the disagreement between early psychological theorists about the nature of human experience and how it should be studied. They argued that psychology’s historical privileging of epistemology and method has excluded other

philosophical concerns such as the need for an explicit ontology. By adopting an empiricist methodology in order to gain scientific credentials, psychology has effectively locked itself into a methodological prison whereby the only means of understanding the nature of reality is through materialism. This grounding in materialism has left metaphysical aspects important to counselling psychology, such as intentionality, agency and the phenomenological essence of experience, non-existent or meaningless as they can not be studied empirically in a materialist sense. The human sciences approach so fundamental to the theory and practice of counselling psychology became marginalised in favour of the natural sciences (Rennie, 1994). However, counselling psychology has called for a methodological diversification, and as such has led the way in exploring the depth and complexity of human experience through conducting qualitative research (Morrow, 2007). Counselling psychology's ontological conflict lies between adopting a constructivist-interpretivist, postpositivist, and even a critical-ideological position on how to understand 'reality' and the methods use to investigate it (Ponterotto, 2005).

3.3.3 Methodology and Axiology in Counselling Psychology

Stanton Rogers (2009) adopted the term 'logics of inquiry' from Blaikie (2000) to talk about the underlying philosophical ideas inherent to different forms of empirical research; this means that the area of inquiry must have epistemological and ontological assumptions that suit the research method. However, this raises some interesting questions with regard to methodology. While critiques of qualitative research concern the more 'practical' considerations, such as its time consuming nature (e.g. McLeod, 2003a), more critical question may concern the 'causality' dilemma of whether epistemology and ontology arise out of methodology, or vice versa. So for example, does the researcher develop an idea to suit a methodology or choose a methodology to suit an idea? This in turn appears to be

connected to axiology, or the role and values of the researcher in the research process (Ponterotto, 2005). The axiology of counselling psychology would lie between a constructivist-intrepretivist, where the researcher's values are considered to be an inevitable part of the research process and should be discussed extensively, postpositivist, where researcher values must be kept in check so as not to influence the study, and critical-ideological, where researcher values are central to the research endeavour, positions (Ponterotto & Grieger, 2007). Methodology and axiology's relationship to epistemology is that they both lie within the broader knowledge culture, and therefore play an important part in the evaluation of that knowledge (Carter & Little, 2007). In counselling psychology, with its 'valuing' of the subjective experiences of individuals it seems reasonable to say that idiographic (i.e. qualitative) research would be chosen over nomothetic (i.e. quantitative), and thus qualitative methodologies would be the preference (e.g. Nicolson, 1995). The aim of qualitative research is to 'understand and represent the experiences and actions of people' (Elliott *et al.*, 1999: 216). The current debate surrounding the use of methodology in psychology can be seen as originating from fundamental disagreements regarding ontology, whereby the need for methodological pretension preceded an understanding of the content of psychology thus leading to a diversification of methods to explore reality (Yanchar & Hill, 2003). Counselling psychology's epistemological, ontological and axiological assumptions appeared in line with the philosophy underpinning qualitative research, which resulted in a marriage between what was seen as a methodology related to practice (Rennie, 1994; Morrow, 2007). However, as pointed out by Alvesson and Sköldbberg (2009), it is epistemology and ontology that is more important than 'methods', and because of this qualitative research gains the upper hand as there is more room for interpretative possibilities and it allows for the researcher's constructions of what is being explored to become more visible.

3.4 ‘Schizophrenia’

Counselling psychology’s conflicted conceptual framework will now be explored in relation to the medical model debate and the use of diagnostic categories such as ‘schizophrenia’. A brief introduction will be made to the medical model of mental distress and the emergence of diagnostic categories. Subsequently, the relationship between the medical model and counselling psychology will be examined critically, particularly as it applies to the diagnosis of ‘schizophrenia’.

3.4.1 *The Medical Model Debate*

The medical model has a perceived history dating back to antiquity, but it was not until the Renaissance when mental illness was seen in a different light, and individuals such as Pinel in the 1700s based their theories of organic mental disorders on the renewed interest of the human sciences while paralleled by a reliance on naturalistic explanations of human behaviour (Kyziridis, 2005). This laid the foundations for a set of fundamental assumptions regarding the nature of mental disorders, including: that they were naturally occurring categories; that they were inherited categories with a predictable deteriorating course; and, that the symptoms of mental illness were caused by diseases of the brain and the nervous system (Pilgrim, 2007). During this time of ‘reason’, society sought to rid itself of the ‘unreasonable’, giving rise to the asylums which would house them and the professionals who sought to ‘cure’ them; psychiatry was the direct product of this act (Bracken & Thomas, 2001). The framework for the organisation of mental disorders was developed particularly by Kraepelin in the late 1800s, who contributed the most to the foundation of the modern concept of ‘schizophrenia’, then known as *dementia praecox* and later given its current name by Bleuler (Andreasen, 1997; Adityanjee *et al.*, 1999). Kraepelin’s organisation of mental

distress supported the idea that that distress can be legitimately and accurately categorised (Boyle, 1999), thus laying the foundations for diagnosis and the eventual development of the DSM (Cooper, 2004), also known as a neo-Kraepelinian approach (Double, 1990). The modern assumptions of the medical model of mental distress have been outlined by Scheff (1999), including: causes of mental illness are largely biological; types of mental illness can be classified using the DSM; and mental illness can be treated safely and effectively with psychoactive drugs. The manualised approach to mental distress through the DSM also resulted in the legitimisation of a profession whose sole responsibility lay in diagnosing and treating individuals considered mentally ill; psychiatrists became the custodians of the medical model and continued to conceptualise distress using medical terminology, thus treating mental disorders like they would any other physical disease or illness, through drugs, surgery and other forms of physical and organic interventions (Laungani, 2002).

The medicalisation of distress and the use of diagnostic labels placed the source of distress firmly within the individual; this may foreclose consideration of the social context and interpersonal relations as sources of unhappiness or dysfunction (Hare-Mustin & Marecek, 1997). As a result of the medical model, psychological theory has proposed a neat division of mental states: the 'neurotic' ('normal' anxiety) and the 'psychotic' ('madness'); this allows professionals to differentiate between the 'worried well' and the 'insane', and it is this division that determines the type of treatment received, with the neurotic receiving counselling and psychotherapy, and the psychotic receiving drug treatment, electro-convulsive therapy and hospitalisation (Marshall, 2004). However, the medical model's problem focus, which places the problem within the individual, and the failure to include more 'recursive' causality, is inconsistent with counselling psychology's identity and values (Eriksen & Kress, 2006).

In contrast to the medical model, a critical approach to mental illness would argue for the social construction of diagnoses such as ‘schizophrenia’: ‘Social construction holds that knowledge rests heavily on social consensus. Our social experiences and interactions shape what we take to be reality and what we regard as truth. Social construction emphasises that language is not simply a mirror of reality or a neutral tool. Language has the power to structure social reality’ (Hare-Mustin & Marecek, 1997: 105). What we call truth can never be completely objective and free of cultural biases; even scientific communities operate within particular forms of meaning and language that shape their perceptions of meaning: ‘Therefore, all conclusions about reality, including scientific ‘findings’, could not possibly refer to an objective reality that exists independent of the group that drew the conclusions’ (Hansen, 2004). Gergen (1985) and Burr (2003) argued that there is no single definition for social constructionism, but that its epistemological position follows assumptions of: (a) a critical stance towards taken-for-granted knowledge; (b) the way we understand the world has historical and cultural specificity; (c) that knowledge is sustained by social processes; and (d) that knowledge and social action go together. Social constructionism is seen as a useful theoretical resource from which to analyze the diagnosis of ‘schizophrenia’ as a historically specific concept and to explore the different ways in which it functions in different domains of culture (Harper, 1999).

3.4.2 Diagnostic Categories

The use of a medical model of mental distress has encouraged the development of diagnostic categories, with the most prevalent diagnostic manuals used being the DSM and the World Health Organization’s *International Statistical Classification of Diseases and Related Health Problems* Mental Disorders chapter (WHO, 1994), hereafter ICD. The DSM

and the ICD have been seen as being reliable and operational tools that have greatly facilitated practice, teaching and research by providing better delineation of syndromes (Üstün *et al.*, 2002) and provided a common language for mental health clinicians and researchers to communicate about mental disorders (Regier *et al.*, 2002). The DSM was developed as a classification system to be used for the diagnosis of mental illness, and it has now become the *lingua franca* for the entire culture and economy of the mental health establishment (Wylie, 1995). Its development went hand in hand with the development of psychiatry and clinical psychology as professions, and in some ways helped to justify their professional existence. As Bentall (2004) highlights:

‘In the USA, the manual was widely embraced both by psychiatrists and psychologists fearful that, without a DSM-III diagnosis for each of their patients, payment from health insurance companies would not be forthcoming. Many journals would not accept papers for publication unless investigators could reassure their readers that the patients studied had been diagnosed according to the DSM-III system, thus ensuring that the criteria became the standard among researchers, not only in America but also elsewhere in the world’ (p.62).

The use of the DSM became firmly entrenched in the world of mental health theory and practice; and in the case of psychiatry and psychology, the DSM became a justification for existence as it anchored their practice in the medical world, ensuring funding and respectability as professions; it was psychiatry and psychology as a form of industrialisation. Theories, assumptions and methods do not exist independently of those who use them in their activities; mainstream psychologists, and others whose activities depend upon psychology’s status quo, will often have a professional interest in supporting and maintain particular forms

of knowledge (Nightingale & Neilands, 1997). This industrialisation worked alongside the pharmacological approach to mental health problems, leading to the argument that ‘Pharmaceutical companies are actively involved in sponsoring the definition of diseases and promoting them to both prescribers and consumers. The social construction of illness is being replaced by the corporate construction of disease’ (Moynihan *et al.*, 2002: 886).

The use of these manuals has come under fierce criticism, particularly the DSM, due to its regular use in mental health practice, with arguments targeting the idea of ‘diagnosing’ mental health problems as if they were ‘diseases’, ‘illnesses’ or ‘disorders’: ‘These claims are suspect because they smuggle into existence the problematic terms “disease” and “illness” and give the false impression that there exist “out there” readily recognisable phenomena called diseases which naturally form the subject matter of psychiatry’ (Boyle, 2005: 86-87). Diagnostic categories have been accused of being little more than attempts to confirm current psychiatric practice rather than classifications based on empirical studies (Scheff, 1999). The greatest problem with diagnostic categories is that they end up creating their own objectivity through the use of everyday practices, for example through the training of clinicians and the publication of journals, when to the contrary they are largely socially constructed (Pérez-Álvarez & García-Montes, 2007). Service users have also criticised the use of diagnostic categories to describe their difficulties, whereby there is a feeling that diagnoses are value judgements that serve to alienate the individual diagnosed leading to a sense of powerlessness and victimisation (Campbell, 2007). People who hear voices have started challenging the medical model of ‘schizophrenia’ and have attempted to develop new coping strategies that exclude the extensive use of medication (e.g. Romme & Escher, 1993; May, 2007). An attempt to integrate the DSM with counselling psychology has been argued as being incongruent with the developmental and contextual identity of the profession (Eriksen &

Kress, 2006), however, it has also been argued that opposing the DSM is futile due to its political nature (Sequeira & van Scoyoc, 2002) and by doing this counselling psychologists are in danger of becoming marginalised professionally within the mental health system. This issue is crucial to counselling psychologists as they are confronted with a moral-political choice about where their allegiance should lie, while at the same time avoid being diagnosed themselves by the mental health profession due to their own supposed resistance to diagnostic categories (Parker, 1999c).

3.4.3 The Diagnosis of 'Schizophrenia'

The concept of 'schizophrenia' has long been one of controversy in psychiatry and psychology, and since its original classification as *dementia praecox* by Kraepelin in 1896 there has been disagreement with regard to its nature; there is no consensus regarding aetiology and pathogenesis; and, there is a current debate whether 'schizophrenia' should actually be considered a distinct mental illness at all, even going so far as calling for the abandonment of the concept altogether (Bentall *et al.*, 1988; Read *et al.*, 2004a; Boyle, 2005). If nobody can agree on who has 'schizophrenia', then the supposed properties of 'schizophrenia' cannot be evaluated. The people one researcher studies will be different from those studied by others (Read, 2004). This difficulty in operationalising 'schizophrenia' is due, in no small measure, to researchers' inability to specify the fundamental nature of the 'illness' or to define its clinical boundaries (Heinrichs, 1993).

'Schizophrenia' is defined as being 'a major mental disorder...characterized by positive symptoms such as delusions, hallucinations, disorganized speech, grossly disorganized behaviour, or catatonia; negative symptoms such as affective flattening, alogia, or avolition; and, marked deterioration in work, social relations, or self-care' (Colman, 2006:

672); this definition includes the positive and negative symptoms that define ‘schizophrenia’ as a mental health problem. The ‘illness’ theory of ‘schizophrenia’ sees it as a biological condition, this is based on purported findings such as that it occurs uniformly across the globe, with the usual occurrence being 1 per cent of the population; that the brains of people diagnosed with ‘schizophrenia’ are different from the general population; that there are genetic predispositions to ‘schizophrenia’, and, that one of the causes of ‘schizophrenia’ is an imbalance of chemicals in the brain, particularly dopamine, which has supported the pharmacological maintenance of the condition (see Read *et al.*, 2004a for a detailed account). Current trends in the mental health professions see ‘schizophrenia’ as a disease-like degenerative process, and is responsible for unwarranted and destructive pessimism about the chances of ‘recovery’ and has ignored – or even actively discouraged discussion of – what is actually going on in these people’s lives, in their families and in the societies in which they live (Read *et al.*, 2004a). Historically, the diagnosis of *dementia praecox* most often led to therapeutic nihilism and recommendation of lifelong institutional care (Rothman, 1971) and the current label of ‘schizophrenia’ brings with it great stigma to individuals, which can be detrimental to their lives, with the most commonly cited being difficulties in making and keeping friends, difficulty in finding a job and loss of self-esteem (Wahl & Harman, 1989). Even with the advent of more moral and humanizing treatment, ‘schizophrenia’ patients today continue to suffer impoverished, socially marginalised existences, and their needs are poorly served by services that are designed more to contain dangerous behaviour than to help people in psychological distress (Laurence, 2003). The dominance of the medical model and the conceptualisation of ‘schizophrenia’ as a biological disorder has resulted in an exclusion of the importance of the therapeutic relationship and denied the possibility that psychotherapy can be useful to serious mental health problems (Repper, 2002).

Using the therapeutic relationship to be with clients diagnosed with ‘schizophrenia’ has been criticised as being indefinable and irrelevant to mental health practice (Coleman & Jenkins, 1998), and the absence of randomised control trials and controlled evidence in the role of the therapeutic relationship has been seen as proof of its lack of efficacy (Lambert & Gournay, 1999). Gallagher and colleagues (1991) found that in a study of 150 psychologists’ beliefs about their role in the treatment of ‘schizophrenia’ there was a 91% disagreement with the statement that ‘schizophrenia’ is too severe a condition for psychologists to work with. Instead they found that clients labelled ‘schizophrenia’ were thought to be unrewarding to work with, and that working with ‘neurotic’ clients was found to generate more success. Similarly, Servais and Saunders’ (2007) survey of 306 clinical psychologists’ perceptions of individuals with mental illness found that individuals with the ‘schizophrenic’ label were viewed as being ineffective or incomprehensible to work with. In Lewis and Bor’s (1998) study of how counselling psychologists are perceived by clinical psychologists, it was found that 60% (97) of the respondents did not feel that psychotic individuals should be referred to counselling psychologists, and that counselling psychologists would be best suited to work with adjustment problems (i.e. marital problems, bereavement, relationship difficulties). However, it is important to consider that 70% (112) felt that they did not have sufficient knowledge about the training requirements of counselling psychologists, and that 65% (105) stated that they knew too little about the competence of qualified counselling psychologists. This survey indicates that there is confusion about the training and abilities of counselling psychologists and the potential role they might play in working therapeutically with individual diagnosed with ‘schizophrenia’.

The medical model is the dominant conceptual model for the understanding of ‘schizophrenia’; individuals diagnosed with ‘schizophrenia’ are ‘in most cases called

“patients”, reside in “hospitals”, and are “diagnosed”, given a “prognosis”, and “treated”, all a reflection of this dominance’ (Furnham & Bower, 1992: 201). The medical concept of ‘schizophrenia’ is justified and maintained through the use of medical discourse; discourse refers to patterns or regularities in the way we talk or write (and by implication, think) about particular phenomena; the idea of ‘schizophrenia’ is written and spoken about by mental health professionals as if it reflected a reality already discovered, or just about to be discovered (Boyle, 2005). This is similar to naming and framing, whereby diagnoses such as ‘schizophrenia’ are just beyond our ability to measure them, when to the contrary, they are largely socially constructed through discourse (Brown, 1995). Gergen’s (1997) cycle of progressive infirmity can be used to outline this idea through four interconnected phases: (1) *deficit translation*, whereby problems experienced in life are converted into the language of mental disorder; (2) *cultural dissemination*, turns mental disorder into everyday concepts; (3) *the cultural construction of illness*, the social practices that teach us to be mentally ill; and (4) *vocabulary expansion*, establishes a methodical medicalisation and psychologisation of everyday life (e.g. Torrey, 2006). Discourse is therefore not simply about words, instead, the way we speak or write about an ‘object’ in a particular way is to ‘construct’ and make seem reasonable a particular version of reality (e.g. ‘schizophrenia’ is a biological disorder and can be diagnosed), this invites or makes reasonable particular kinds of actions or responses (e.g. individuals diagnosed with ‘schizophrenia’ should therefore be treated with medication) (Boyle, 2005). Through discourse, ‘schizophrenia’ is often presented as the last bastion of mental illness with a neurobiological basis; however, it is problematic to assume that there are essences or inherent qualities that would represent the truth of his or her abnormality, as far from being an a human essence, abnormality is considered a construction (Pérez-Álvarez & García-Montes, 2007); as Zachar (2001, 2003) states, mental disorders such as ‘schizophrenia’ are not natural kinds, but rather practical kinds constructed on a pragmatic

basis. Available discourses on conditions such as 'schizophrenia' are not equal in power, with some being more hegemonic or unitary; that is they assume the status of facts and they are considered true and accurate descriptions of the world (Turner, 1995). Medical discourse, and the use of diagnoses in particular, has been shown to be a powerful hegemonic discourse that serves to determine the criteria for normality, to define what is considered valid knowledge, who has access to this knowledge and how this knowledge can be communicated and to whom (Samson, 1995). The use of psychiatric diagnoses objectifies the individual who has been diagnosed, provides subject positions that are constraining, pathologises and disempowers, and limits the individual's freedom to position themselves in relation to other discourses (Sampson, 1993). Similarly, counselling psychologist might also find themselves constrained by the same medical discourse that constrains the individual who has been diagnosed, whereby they 'fall victim to the mystification of medical knowledge in psychiatric vocabulary and discourse' (Hook & Parker, 2002: 52).

Dominant discourses privilege versions of social reality that accord with and reinforce existing social structures and the networks of power relations associated with them. Discourse analysts study the availability of discursive resources within a culture and the implications that this carries for those living within that culture (Coyle, 2006). While discourses legitimate and reinforce existing social and institutional structures, these structures, in turn, also support and validate the discourses (Willig, 2009); Foucault took the position that discourse has no inside (in thought, ideas, opinions) and no outside (in things that words refer to) (Kendall & Wickham 1999). Discourses have no 'truth value'. They are not true or false. 'Schizophrenia' is not an idea that exists in the minds of psychiatrists or outside in the bodies of people. Rather, it appears (is inscribed) historically, and intangibly, as something that lies on the surface of an interconnected web of statements and techniques.

Thus, 'schizophrenia' becomes visible (and changing) through statements (the sayable) about the nature of 'schizophrenia' (for example, as biological dysfunction or psychological disturbance) and statements are produced through the visibilities of techniques (for example, medication or psychotherapy). As Gergen (1999) argued, 'structures of language are used to build favored realities' (p.64), which are then supported through the desirability of 'conditions' such as 'schizophrenia'. Boyle (2005) pointed out that this maintenance is pursued by both psychiatry and the public, whereby the idea of 'schizophrenia' as a medical conditions helps in maintaining links between psychiatry and the medical profession, thus legitimizing the pursuit of 'schizophrenia' as a hallmark of professional identity. For the public, the concept of 'schizophrenia' as a biological disorder helps to absolve the 'victim', their relatives and society in general, from the responsibility of having caused the person's disturbing behaviour: 'by providing a name, a label, professionals convey the powerful and comforting message that they are familiar with these behaviours and experiences, that they have seen them before and (it is implied) have some understanding of them. "Schizophrenia" is therefore a highly seductive label, for professionals, for relatives, for the public and for those whose behaviour has given cause for concern' (Boyle, 2005: 242). This draws attention to how the power constituted by discursive and institutional bases is productive of professional positions, and illuminates how a certain discursive/institutional domain delimits the way in which such problems may be understood (Hook & Parker, 2002).

However, there have been alternative views on 'schizophrenia', which have developed within their own temporal and cultural contexts. Geekie and Read (2009) outlined both 'lay peoples' and professionals' views on the diagnosis of 'schizophrenia'. With regard to lay people there appeared to be a view that favoured more environmental and social explanations over medical ones, with common causes including traumatic experiences or the

failure to negotiate a critical stage of emotional development. This led Furnham and Bower (1992) in the United Kingdom to conclude that: 'It seems like lay people have not been converted to the medical view and prefer psychosocial explanations' (p.207). Similar results were found in other countries including Australia (Jorm *et al.*, 2005), Ireland (Barry & Greene, 1992), Germany (Angermeyer & Matschinger, 1996), as well as in China, Japan, Malaysia, India, Ethiopia, Russia, South Africa and the USA (see Read *et al.*, 2006). Geekie and Read (2009) conclude by saying that the family members of the individuals diagnosed with 'schizophrenia', and the individuals themselves, also tend to have the same social views as the general public, suggesting that 'commonsense "folk" notions both of one's own mental health and of the behaviour of others prefigure professional and technical psychiatric terms' (Parker *et al.*, 1995: 57). However, that some 'experts' dismiss this view and use it as a proof that the individuals have no 'insight' into the claimed 'fact' that they are suffering from an 'illness', and as pointed out by Banton and colleagues (1985, cited in Parker *et al.*, 1995), the idea that social factors somehow influence an entity known as 'schizophrenia' masks the notion that the diagnosis of 'schizophrenia' is socially constructed.

Besides the bio-medical model, a number of different and often conflicting theories about the cause and nature of 'schizophrenia' have arisen as outlined by Geekie and Read (2009). These include evolutionary theories (e.g. Horrobin, 2002); neuropsychological (e.g. Frith, 1992); psychological theories (e.g. Bentall, 2004; Boyle, 2005); psychodynamic and psychoanalytical (e.g. Sullivan, 1962; Karon, 1999); life event theories (e.g. Read *et al.*, 2004b); sociological and anthropological (e.g. Littlewood, 1991; Rosenhan, 1973); and, philosophical and existential theories (e.g. Laing, 1990a; Sass, 1992) and others. Considering the diversity of these approaches and how many how of them have been adopted by

counselling psychology's value base, it is no surprise that counselling psychology appears to have a conflicted view of diagnoses such as 'schizophrenia'.

3.5 Counselling Psychology and 'Schizophrenia'

This section aims to explore the counselling psychology literature as it pertains to the diagnosis of 'schizophrenia'. As the literature is particularly sparse on 'schizophrenia' itself, it is hoped that by reviewing literature surrounding diagnostic categories and counselling psychology a sense will be provided of where counselling psychology stands in relation to the diagnosis.

3.5.1 Counselling Psychology and Diagnostic Categories

Douglas (2010) argued that the location of counselling psychology practice has changed since the 1990s, with a move towards working in statutory organisations and mental health services within the NHS. One of the questions raised because of this move is:

'how to retain a humanistic value base within a framework dominated by a medical model of distress in which treatment guidelines focus on disorder, in which the burgeoning industry of manualised, protocol-based therapy for specific disorder and is promulgated, and in which therapy could be argued to be the adjunct to the politics of employment. Within such a framework, therapies and their research bases, are premised on the notion of disorder and its classification' (p.24).

This appears to be one of the central questions when considering counselling psychology's relationships with diagnostic categories such as 'schizophrenia', and was also asked by Strawbridge and James (2001), Sequeria and van Scoyoc (2002), Turner-Young

(2003), Golsworthy (2004), Bury and Strauss (2006), Lane and Corrie (2006), Douglas (2010) and Milton and colleagues (2010).

Strawbridge and James (2001) raised issues regarding the questionable nature of diagnostic categories, the power of labelling, the pathologizing of distress, the appropriate use of psychiatric categories within specific contexts, practitioners working within their competence in relation to the categories, lack of informed consent, the potential discouragement of service users and the financial consequences of the use of psychiatric language particularly related to funding and insurance. They argued that because we exist in a climate where we are forced to claim and justify our expertise we might be drawn into a medicalised framework because the use of psychiatric categories: ‘are seen as offering an interdisciplinary and international language as well as enhancing a “professional” image in a highly competitive market’ (p.4). Although Strawbridge and James raises issues related to the more ‘theoretical’ questions surrounding the use of diagnoses, they appear to be firmly grounded in a form of ‘realism’ that sees the use of diagnoses as related to the issue of employment and ‘professional image’.

Sequeira and van Scoyoc’s (2002) round table discussion on the DSM-IV and psychiatric testing raised similar issues relating to the maintenance of a professional identity grounded in humanism while at the same time being able to compete in a ‘market’ where psychiatric discourse is dominant. Contributors from the floor appeared to have more radical views, including: ‘We should stand against the DSM-IV as it is not grounded in any psychological or even medical categories...it is political’; ‘Once we know a language, e.g. DSM, we tend to use it and can’t see through different lenses. We need to stay peripheral so we can stay critical’; and ‘There is a problem with people not having access to second

opinions. For example people of colour frequently labelled with schizophrenia. With DSM no thought is given to alternative theories about experience' (p.46). There were also more cautionary comments about attempting to include the use of psychiatric diagnoses into practice, as well as the consequences of not using them, including: 'It is futile to wage war against the DSM...The problem or question we should be addressing is HOW [emphasis in original] it should be used, not whether it should be used'; 'If I have a client with a wrong diagnosis, I can use my knowledge to argue against it'; 'What I am feeling throughout this process is FEAR [emphasis in original]. I fear I can't use these. It is the fear of not knowing'; and 'This has brought up in me a fear of judgement. I am judging the clients and I am being judged by colleagues' (pp.46-47). Although Sequeira and van Scoyoc do not present a critical analysis of the use of psychiatric diagnoses, what is presented is an example of the conflicted views within counselling psychology in relation to their use.

Turner-Young (2003) questioned the growth rate of diagnostic categories and argued that the increase of the categories leads to an increase of pathological normal human behaviour. She relates the use of diagnostic categories to Mahrer's (2000) belief in the philosophical values underpinning psychotherapeutic endeavours, including: 'Scientific research on psychotherapy is to test and thus confirm or disconfirm testable hypotheses'; 'Biological, neurological, physiological, and chemical events and variables are basic to psychological events and variables'; and, 'There are mental illnesses, diseases and disorders' (p.1117). Mahrer's arguments are in turn contrasted with Spinelli's (2001) concerns regarding the presence of 'Foundational Beliefs', such as the use of 'accepted phrases' (e.g. borderline disorder or conditioned response) and 'Common practices' (e.g. diagnostic assessment), and how these are used in the service of the profession. Spinelli goes on to argue that 'Foundational Beliefs' are themselves highly immune to critical appraisal and the

idea of going against your own 'Foundation Beliefs' (i.e. attacking counselling psychology's own conflicted value base) is highly contentious. Turner-Young concludes this by stating that: 'It is always easier to stay with a bad habit than to change and practise a new way of being; similarly it is easier to bow to peer pressure than to stand alone or with a minority and challenge the validity of the "old guard"' (p.54).

In Golsworthy's (2004) article, he argued that:

'It is not enough for Counselling Psychologists to say that, for example "I don't work in that way", any more than to blindly accept such a classification and the limitations in conceptualising individual concerns that it fosters. It is essential to be able to engage actively with this system, to be knowledgeable about it, and to understand both its strengths and limitations. Counselling Psychologists need to be able to reflect on the questions raised by the categorisation of suffering, as well as considering the ways in which diagnostic systems influence our practice, for good and bad, implicitly and explicitly' (p.23).

Golsworthy states that it is our societal duty to challenge psychiatric categories and diagnoses even though this may lead to forms of professional conflict. He points out that through the use of the therapeutic relationship counselling psychologists must question their own assumptions and any supposed supremacy of particular form of knowledge. Compared to the other individuals cited in this review, Golsworthy appears to take a more politically charged position towards the use of psychiatric diagnoses and argues that we need to understand psychological distress rather than label 'it'.

Bury and Strauss (2006) presents a similar dilemma about the use of psychiatric diagnoses, however, they approach it from the perspective of counselling psychology's acceptance of the scientist-practitioner model. Although they argue that 'We do not work from an assumption of pathology. Our clients typically come because of their own desire to better understand and explore some aspects of their lives' (p.12), there appears to be an ambivalence about where counselling psychologists decide to align themselves on the continuum between 'a more clinical model' and a more relational one. This appears to be one of personal choice, with arguments for and against the relational model being presented in relation to the scientist-practitioner model. However, this is problematic, for as argued by Albee (2000) the engagement with the scientist-practitioner model implies an engagement with the medical model.

Lane and Corrie (2006) presents a review that touches slightly on the issues relevant to this research. Indeed, it appears as if the arguments presented in Lane and Corrie's paper are identical to the ones presented by Bury and Strauss above (this should not be considered unusual as Lane and Corrie were authors of the book in which Bury and Strauss' chapter was originally published in). However, they do add to the argument by citing Goldfried and Eubanks-Carter (2004) and by highlighting the different types of critical research related to 'psychopathology'. They point out that the difference between traditional research on 'psychopathology' and research within the field of counselling psychology is that the latter focuses more on process, such as *how* change occurs, rather than on what *needs* to be changed or what *has* occurred, such as in the case of randomised trials.

Douglas (2010) provides a more historical overview of 'disorders' as they are called in her chapter, and presents the DSM and psychiatric diagnoses as epistemological positions

which are reinforced ideologically through a 'silent sign system' as suggested by Barthes (Brown, 2005). This, she argues, turns the idea of pathology into a system which we are encouraged to accept as a norm. Douglas presents an example of what may be the most 'critical' stance towards psychiatric diagnoses and asks whether they can be classified, whether they are useful and if they are natural kinds. This certainly provides a more comprehensive review in comparison to the others studies discussed, and asks questions which are of interest to this research. She concludes that what is presented as a 'disorder' is, indeed, a conceptual framework (Cooper, 2004) and asks whether it is counselling psychology that is being 'thingified' (Tillich, 1988) in its pursuit of treatment for 'disorders' and not the 'disorders' themselves.

Finally, Milton and colleagues (2010) took a more 'postmodern' position on the subject and identified a dilemma inherent to counselling psychology: 'on the one hand, there is an espoused utility of scientific psychology and, on the other, there is a recognition that understandings of "psychopathology" are negotiated and constructed via sociocultural and historically-specific meanings' (p.58). Milton and colleagues argue that there is a difficulty with modernist notions of 'psychopathology' existing in a postmodern age, when the topic can be approached from a variety of angles. More specifically in relation to counselling psychology, they argue that the professional setting which counselling psychologists may find themselves in have the potential to cause tension as they may be subject to 'prevalent discourses that shape the applied context in which counselling psychologists work' (Craven & Coyle, 2007: 246). This echoes Douglas' (2010) comments about the retention of counselling psychology's 'humanistic value base' and respect for the phenomenological.

What appears to be lacking from a majority of these reviews, which is of interest to this research, is the conflicted position in which counselling psychology finds itself in relation to its own epistemological value base. There appears to be an appeal to the ‘humanistic’ side of counselling psychology, and a positioning of the profession in a hostile world where ‘modernist’ discourses reign supreme, and where counselling psychology’s ‘postmodern’ view has the potential to counter dominant regimes of truth (Foucault, 2002) with its own pluralistic framework. However, this in itself appears to be a rhetorical strategy as there is no acknowledgement that counselling psychology is itself rooted in modernism with an empiricist grounding in psychology and an alignment with the idea of the ‘scientist-practitioner’ (e.g. Corrie & Callahan, 2000), of which Albee (2000) argued had an uncritical acceptance of the medical model.

3.5.2 Theory and Practice in Counselling Psychology

The relationship between what constitutes theory and practice in counselling psychology will now be reviewed, although such an account is inevitably complex it is hoped that this will provide a brief outline. This is relevant as it helps to gauge what counselling psychologists might believe constitutes the diagnosis of ‘schizophrenia’ and how this might affect their perceived ability of being able to work therapeutically with individuals diagnosed with said condition. As mentioned previously, counselling psychology has attempted to create an identity in order to distinguish itself from other areas of applied psychology and, as Woolfe (1990) argued, one of its critical characteristics is its focus on the therapeutic relationship:

‘One of the primary contributions which counselling psychology has to offer psychologists is the value it places on the subjective experience of its clients. The

sharing of this inner reality helps to cement the relationship between client and helper and acknowledges the importance of each individual's construal of life experiences' (p.532), and that 'the more that the self of the therapist is conceived as an active ingredient in the counselling process, the more incumbent it becomes on counsellors to develop the level of understanding of their own psychological processes' (p.532).

Counselling psychologists are encouraged to pay great attention to defining the therapeutic relationship, and to attend to it throughout the course of therapy. This acknowledges the belief that it is the nature of the therapeutic relationship which is fundamental to the progress and outcome of therapy, and the therapist plays an integral part in that relationship (Lewis & Bor, 1998). As Magnavita (2000) argued, a relational approach is one in which the 'therapeutic process is held to rely most heavily on the quality and mutual experience of the client-therapist relationship rather than on any particular set of techniques' (p.999). Rather than pathologising difficulties and distress, and looking at them as 'illnesses' and 'disorders', the counselling psychologist 'advocates an interactive alternative that emphasises the subjective experience of clients and the need for helpers to engage with them as collaborators, seeking to understand their inner worlds and constructions of reality' (Strawbridge & Woolfe, 2006: 11).

However, how might counselling psychology's theoretical and practical philosophy be used in working with individuals diagnosed with 'schizophrenia'? Clients diagnosed with 'schizophrenia' have reported viewing the therapeutic relationship as the most important element of psychiatric care (Johansson & Eklund, 2003). The importance of the relationship has been acknowledged and carried over to the most current guidelines on working with schizophrenia; the *National Institute for Clinical Excellence* (NICE) (2003) guidelines states

in its clinical summary of psychological interventions that ‘empathic relationships between people with schizophrenia and their professional carers, in which sympathetic listening plays a central part in developing the therapeutic alliance, are an essential part of good practice’ (2003: 102). Recent research into the outcome of individuals diagnosed with ‘schizophrenia’ has tended to focus on the technical aspects of working with the condition, and ignored non-specific factors such as the relationship (Bentall *et al.*, 2003), and there is currently a lack of research focusing on the therapist in establishing a therapeutic relationship with a client diagnosed with ‘schizophrenia’. Howgego and colleagues’ (2003) review of 84 published articles pertaining to the care of clients with severe mental health problems found that the therapeutic alliance was measurable, and that its establishment improved client outcome. Frank and Gunderson (1990) found that schizophrenia patients who had good relationships with their psychotherapists tended to comply more with their medication regime. With the rise of the recovery movement among individuals diagnosed with ‘schizophrenia’, patient-reported outcomes are increasingly used to evaluate the care provided for these individuals (McCabe *et al.*, 2007), and in focus groups where individuals diagnosed with ‘schizophrenia’ were asked to rate the core competencies of mental health workers, they valued a trusting relationship with their mental health worker over technical skills (Institute for Health Care Development, 1998).

In working with a condition such as ‘schizophrenia’, often because of its complex nature, the treatment must be multimodal, comprehensive and tailored to each client’s progress and response (APA, 2004). Dingman and McGlashan (1989) argued that the implementation of therapy with schizophrenia should be one that:

‘uses a variety of strategies applied flexibly depending upon the individual patient and his or her type and phase of “schizophrenia”. We conceive of psychotherapy as a continuous relationship between patient and doctor/therapist which is primarily clinical in nature but which is informed and guided by psychotherapeutic principles’ (p.264).

Carpenter (1986) argued that divisions between psychotherapeutic ideologies undermined the efforts to integrate approaches that should be considered complementary; with the therapeutic relationship providing the foundation, and the integration of treatment modalities based on the phenomenological understanding of each individual client’s needs. Roth and Parry (1997) found that randomised controlled trials tended to measure the outcome of therapy, as opposed to process, and efficacy rather than effectiveness; they argued against the possibility of studying psychological approaches using the same methods as evaluating the effectiveness of drug treatment, saying that the skilled mental health practitioner adapts their technique in order to maintain the integrity of treatment and the relationship, resulting in the difficulty in achieving a measurable approach. Paley and Shapiro (2002) argue that:

‘it is our opinion that research in this area [psychological interventions for people with schizophrenia] is in danger of becoming too focused around CBT [cognitive-behaviour therapy] to the possible exclusion of other models. Our concern is that this may lead to the premature dismissal of other potentially effective models and hinder the identification of the “active ingredients” and underlying mechanisms responsible for change in both CBT and other psychological approaches to schizophrenia’ (p.6).

An alternative to the medical model of rehabilitation that might be more compatible with counselling psychology's ethos is the recovery model (Deegan, 1996):

‘Recovery is described as a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness’ (Anthony, 1993: 16).

The differences between the recovery model and the medical model of rehabilitation echoes those between counselling psychology and clinical psychology, whereby the former is more concerned with person-centred goals and an evidence base comprising of personal narrative as opposed to the latter’s focus on disease, treatment and biological reductionism (Roberts & Wolfson, 2004). However, Roberts and Wolfson go on to argue that due to the conservatism and skepticism of the medical establishment this approach remains a doubtful one due to the lack of ‘evidence’. Frese and colleagues (2001) had earlier tried to challenge this view and argued that evidence-based practice can be combined with the recovery model. Ng and colleagues (2008) pointed out that the two approaches can be viewed as complementary, such as with the use of person-centred care and CBT advocated by the most current NICE (2009) guidelines on recovery in ‘schizophrenia’, and both contribute to an understanding of the complex phenomenon that is recovery. To counter such an argument, perhaps it is the nature of obtaining ‘evidence’ which should be in doubt instead of the model itself. As Yanchar and Hill (2003) argued, psychology must be open to continual clarification, reexamination and reinterpretation if it to progress; using only one

epistemological view and methodology cannot account for the variety of human experience and ways of exploring them.

Counselling psychology's phenomenological approach to clients should also be considered when looking at the diagnosis of 'schizophrenia'; the association between phenomenology and mental illness, particularly schizophrenia, is long standing, and it can be said that the essential dimensions of schizophrenia from a phenomenological perspective revolve around aspects which are centrally concerned with the person's relationship to the world, self and others (Rulf, 2003). As Boyle (2005) argued, a phenomenological approach to symptoms of 'schizophrenia', such as delusions and paranoia, should be seen as phenomenon in their own right and not indications of a single symptom model:

'But if we step outside a medical framework (which some of those advocating a single symptom approach do not) then the study of 'delusions' and hallucinations as phenomena in their own right is potentially progressive, not least because it allows questions which may make little sense within a medical framework, questions about context, about content and function, and about social and personal meanings' (p.245).

Similarly, Estroff (1989) expressed a need for taking the person, or the subject, back to the centre of inquiries in the nature of 'schizophrenia' and its consequences: 'the social and personal processes of having schizophrenia are not and need not be equivalent to the disease or having the disease. *Becoming a schizophrenic* [italics in original] is essentially a social and interpersonal process, not an inevitable consequence of primary symptoms and neurochemical abnormality' (p.194). However, as Andreasen (2007) pointed out, the warping of phenomenology from its original conception used by Heidegger, Husserl and

Jaspers as a means of understanding subjective experience to its use as a nosological foundation in psychiatric contexts and the development of the DSM led to a discouragement of knowing the patient as an individual, and reduced that individual to a checklist of symptoms.

Counselling and psychotherapy can, in certain circumstances, provide settings for the deconstruction of psychopathology (Parker, 1999d). Instead of locating the source of an individual's distress inside the person, the problem is situated as the product of the historical relationship the individual has forged with others; instead of being something discrete and abnormal, the problem is positioned in relation to the variety of experiences that structure the everyday world; and, instead of being solely the property of the individual, the problem is re-specified as being as much to do with the reactions of the designated professional and what goes on between the ordinary person and the expert world (Hook & Parker, 2002). This anti-diagnostic activity is constructed with the client as part of a process of emancipating the client from the problem, thus leading to further deconstruction by the client as opposed to subjecting the client to the problem using the DSM or ICD (Parker, 1999b). However, given the current contextual factors supporting the use of diagnoses such as 'schizophrenia', is it even possible for counselling psychologists to abandon diagnosis in order to 'practice what they preach' (e.g. Boyle, 2007; Cromby *et al.*, 2007)?

3.5.3 Contextual Factors

As Strawbridge and Woolfe (1996) observe; the identity, roles and activities of counselling psychologists can not be explored separately from contextual factors such as the economic, political and social. A number of contextual factors contribute to the use and maintenance of diagnostic categories within the theory and practice of counselling

psychology (e.g. Jensen, 2006). As Foucault argued, certain ways of talking are facilitated through changing economic, social, scientific and political conditions, which in turn make particular social, economic and scientific developments more likely (Boyle, 2005). The legitimisation of counselling psychology through the BPS has made its existence a reality; however, this reality brings with it certain conditions of existence which will be explored below.

Economic. Research, training and service-delivery all represent endeavours with economic implications, and with counselling psychology being a field of applied psychology in its own right it must take a position in relation to these three matters. The economic factor overlaps with others, and it can be considered the overarching factor as it involves all aspects important to the scientist-practitioner model. In the United States of America the development of the scientist-practitioner model of counselling psychology went hand in hand with the rising need of accountability in the practice of psychology, which was intended to ‘provide a system by which organisations, especially insurance companies, and individuals across the country could readily identify psychologists who had specific education, training, and supervised experiences’ (Munley *et al.*, 2004: 264). In the United Kingdom, however, appropriate accreditation was considered a necessity in order to practise as a counselling psychologist within the NHS. This led to an increase in the teaching of the medical model in counselling psychology programmes in order to gain the understanding necessary to be taken seriously as a member of the applied psychology field and to secure employment within the NHS (Golsworthy, 2004). This necessity was reflected in the training programmes, which aimed to teach students to research and practise within the medical model, thus continuing its use to future practitioners of counselling psychology.

Social. East (1995) likens the medical world to a tribal village society, where newcomers are often regarded with suspicion and hostility. While counselling psychology has attempted to structure an identity unique to itself, it must still, particularly when working within the NHS, partake in the tribal village society. As highlighted with Lewis and Bor's (1998) study on clinical psychologists' views on counselling psychologists, their roles have been ill-defined and they seem to strafe between being regarded as just 'counsellors' and being applied 'psychologists'. However, by placing the word 'psychology' after 'counselling', counselling psychologists have been accused of attempting to seek a hierarchical position for themselves between clinical psychologists and counsellors (Brennan & Hollanders, 2004; Milton, 1995). This places the use of the medical model within larger cultural spheres which counselling psychologists are embedded in, and with this embeddedness comes the assumption that the medical model is the tactic that is currently most acceptable to our society (Mullan, 1995).

Political. Counselling psychology is forced to keep up the pace with other, more established professions in the field of mental health. Because of this it must work within the set parameters already laid down by professions such as psychiatry and clinical psychology, as well as what is expected by clients: 'healers would have a difficult time convincing patients of a practice that was inconsistent with current epistemological and meta-physical systems' (Wampold, 2001b: 70). With evidence-based practice (e.g. Chwalisz, 2003) replacing the scientist-practitioner model, counselling psychologists are required to integrate science and practice in order to demonstrate their ability to practise within a framework which is considered therapeutically sound and open to empirical investigation. However, the differences between the two models have been called into question (Stricker, 2003), and even though this move has raised issues regarding the actual ability to empirically study psychological therapy (e.g. Parry, 2000), it has now become part of a largely political agenda

through the implementation of New Ways of Working (DoH, 2007) and the Improving Access to Psychological Therapies (IAPT) initiative (e.g. Layard, 2006; Care Services Improvement Partnership, 2007). Within this political agenda counselling psychology has been assigned a role (e.g. Clark & Turpin, 2008), but only if it abandons its epistemological position for a value based in the medical model.

Linguistic. Counselling psychology's engagement in a medical model dominated environment means that it is very difficult for the profession to separate itself from the assumptions of the medical model. The way we speak of things not only reveals, but also influences, the underlying assumptions on which the profession rests: 'The language of the medical model permeates the psychotherapy endeavor. Examine the words we use in research and in practice: diagnoses, disorders, treatments, clinical trials, active ingredients, and symptoms' (Wampold *et al.*, 2001: 270). Wampold and colleagues argued that the spirit of the medical model lives on as metaphor in psychotherapy:

'Because several historical roots of psychotherapy are deeply imbedded in a medical model of psychotherapy, because the medical model appears more scientific than various alternatives, and because the economics of practice are imbedded in a health care delivery system, the natural tendency has been to adopt medical model language' (p.268).

Mahrer (2000) warned that the foundational beliefs that our language rests upon, if kept hidden and unexamined, can become immune to change and can be implicitly powerful, leading to a denial of the possibility of change and the construction of alternative models without accompanying alternative language.

3.6 Summary

The literature review presented above has attempted to provide a picture of the development of counselling psychology and its position relative to diagnostic categories, with a particular emphasis on the diagnosis of 'schizophrenia' as presented in the literature. The literature review also wants to demonstrate the potential confusion within counselling psychology relating to this matter, and how, as a newly formed professional identity, counselling psychology appears to be caught between two epistemological models. As counselling psychology moves further and further into the NHS and its medical model orientated philosophy, it appears paramount to explore the views, opinions and ways of working for counselling psychologists that are outside their traditional roles as applied psychologists. However, it is clear that from the distinct lack of literature pertaining to the theory and practice of counselling psychology and the diagnosis of 'schizophrenia' that more needs to be done empirically. This study was directed at the need to provide some organisation, added richness and depth of exploration of how counselling psychologists view the diagnosis of 'schizophrenia' and if their training has prepared them to work with this client group. This review has also attempted to provide some context for the development of diagnostic categories and the diagnosis of 'schizophrenia' itself. As discussed earlier, it should be understood that the way this review is presented is only one way of writing about these issues, and another author may have decided to focus on other matters pertaining to the same issues.

4. Methodology

4.1 Introduction

This study employed a qualitative research strategy based on transcribed interviews of participants, designed to explore language used surrounding the diagnosis of ‘schizophrenia’. Using this method of study allowed the researcher to attempt to understand the participants’ talk in depth and organise the rich information in meaningful ways so that the research questions could be addressed; this section will outline the methodological approach to this study.

4.2 What is Methodology?

Ponterotto (2005) stated that methodology ‘refers to the process and procedures of the research...research method flows from one’s position on ontology, epistemology, and axiology’ (p.132). This suggests that the researcher’s epistemological position influences the methodology used. For example, a researcher who takes an empiricist view of knowledge may gather data through the use of questionnaires and would attempt to strictly control the ‘variables’ under investigation and exclude the researcher’s own position from the research process (Willig, 2009; Ponterotto, 2005). However, the empiricist approach has come into question with the emergence of qualitative research, which argues that knowledge can not be separated from the knower (Steedman, 1991). Qualitative methods refer to a broad range of empirical procedures that aim to describe and interpret the experiences of research participants in context-specific settings (Denzin & Lincoln, 2000); the core assumptions of qualitative research include studying individuals in the natural world, exploring the meanings individuals make of their experiences and investigating individuals in social interaction (Morrow, 2007). Elliott and colleagues (1999) stated that: ‘The aim of qualitative research is

to understand and represent the experiences and actions of people as they encounter, engage, and live through situations. In qualitative research, the researcher attempts to develop understandings of the phenomena under study, based as much as possible on the perspective of those being studied' (p.216). This favours viewing the construction of knowledge, for either theory or practice, as having multiple entry points in the circle of experience and theorizing about that experience (Haverkamp & Young, 2007), which is what has made qualitative methodologies attractive to research in counselling psychology (e.g. McLeod, 2003a). There has often been an 'unproductive' (Alvesson & Sköldberg, 2009: 7) debate between the advantages and disadvantages of quantitative versus qualitative methodologies, however, Alvesson and Sköldberg argued that the choice between the quantitative and qualitative should not be made in the abstract, but should be determined depending on the nature of the research. For the sake of this research the methodological principles as outlined by Teo (2009) will be followed, which argues that methodology is not 'independent from the subject matter and independent from the sociohistorical context from which it emerges' (p.44).

However, qualitative research is not seen as being problem free. As outlined by Yardley (2000) and Angen (2000), questions have been raised about the usefulness of research that is interpretative. For example, Stenner (1993) argued that there are issues of having power over others' words, or as Stainton Rogers (1991) commented: 'in order to weave my story, I must inevitably do violence to the ideas and understandings as they were originally expressed' (p.10). This includes questions of ethics in qualitative research (Haverkamp, 2005), such as the use of interviews, where a power imbalance may be present (e.g. Harper, 1999; Potter & Hepburn, 2005) and where the dialogic interaction between

researcher and the participants increases the risk for exploitation and misrepresentation (Richards & Schwartz, 2002).

4.3 Psychology's 'Turn to Language'

With regards to the methodology in this research, an important issue is 'the turn to language' that occurred in psychology in the 1960s and early 1970s. This 'turn to language', and later to discourse in the 1980s and 1990s (Parker, 2004), has provided a helpful climate for the researcher who wishes to explore the ways in which the field of psychology is socially constructed (Parker, 1996). Edley (2001) stated that the 'turn to language' resulted in an undermining in the twin notions of truth and reality (Burr, 1995); 'In particular, it is thought to have disturbed our understanding of the relationship between representation and reality; throwing into radical doubt the assumption that language maps on to reality in a fairly straightforward manner (Edley, 2001: 434). Although Parker (1992) argued that there are many strands in the 'turn to language' in psychology, some will be briefly outlined here.

As pointed out by Willig (2009), from the 1950s onwards, academics from a variety of disciplines became interested in language as social performance rather than reflective of 'reality': 'The assumption that language provided a set of unambiguous signs with which to label internal states and with which to describe external reality began to be challenged' (Willig, 2009: 92). Language was seen as being productive and constructive of social events, and thus a form of social action (Burr, 2003). Gergen (1985) argued that as doubt developed over the positivist-empiricist conception of knowledge, Wittgenstein's (1963) *Philosophical Investigations* aided the turn to language by exposing the linguistic constraints governing what was then regarded as 'psychological phenomena' such as concepts of 'mind' and 'motivation' (although as argued by Edley, 2001, the roots of this movement stretched back

to other philosophers, including Kant and Nietzsche). However, as will be discussed below, the degree to which Wittgenstein neglected the role of the ‘material’ has been an issue of debate (see Parker, 1996 and Jost & Hardin, 1996), with Parker (1996) arguing that Wittgenstein’s relativism ‘obscures the *material* [italics in original] structuring of contemporary institutional power, power that both inhibits and *incites* [italics in original] speech’ (p.380). Saussure’s (1983) ‘semiology’ challenged the representational view of meaning as something that emerges between objects in the world and the signs that describe them: ‘An important insight which Saussure gives us is that the relation between signifier and signified is arbitrary – every language is free to produce its own relationships between sound-images and ideas. The identity of a sign, its meaning, is determined not by its essential properties, but by the differences that distinguish it from every other sign’ (Hepburn, 1999: 642). Saussure’s semiology gave way to the discourses of the French post-structuralists and deconstructionists, notably Foucault (1972) and Derrida (1976); post-structuralism took with it crucial properties from Saussure’s structuralism, however, it broke with the dominating centre which would govern the structure, the ‘text becomes a ‘free play’ with signs, without anchoring it either in a producer of texts (subject) or an external world’ (Alvesson & Sköldberg, 2000: 148). In the 1970s, social psychologists began to challenge the cognitivism that was present in psychology (Gergen, 1989) and in the 1980s the ‘turn to language’ took a firmer foothold (Willig, 2009) with the publication of Potter and Wetherell’s (1987) *Discourse and Social Psychology: Beyond Attitudes and Behaviour*, which introduced discourse analysis as an approach into ‘mainstream’ psychology. As argued by Parker (1992), the ‘turn to language’ fostered the ‘crisis in psychology’, which in turn led to a discursive framework that made the idea of discourse analysis possible.

4.4 Discourse Analysis

Discourse analysis is the study of language in use, and adopts a social constructionist view of language as context bound, functional and constructive (Avdi & Georgaca, 2007). The use of discourse analysis for this thesis draws on a tradition in British social psychology influenced by the fields of linguistics, hermeneutics and ethnomethodology (Potter & Wetherell, 1987) and Marxism, feminism and critical psychology (Fox & Prilleltensky, 1997) and the writings of Foucault (Parker, 1992). Discourse analysis allows for the exploration of descriptions or constructions of the world and how these descriptions sustain some patterns of social action and exclude others (Burr, 2003). The aim is to present a discourse analysis of counselling psychologists' constructs of 'schizophrenia', and to reframe the psychological concept of 'schizophrenia' in discursive terms from the resources used by counselling psychologists to construct and identify it. Transcripts from semi-structured interviews will be analyzed, wherein the focus will be on the participants' constructs of the label 'schizophrenia' through the use of subject positioning. Subject positions 'allows the analyst to investigate the cultural repertoire of discourses available to speakers. Not only are they positions in which to ground one's claims of truth or responsibility, but they allow individuals to manage, in quite subtle and complex ways, their moral location within social interaction' (Arribas-Ayllon & Walkerdine, 2008: 99). This approach can be viewed as a form of 'practical deconstruction' (Parker, 1999c), which 'reverses the priority given to certain concepts, locates those concepts in certain relations of power and supports resistance on the part of those subjected to them' (p.105). Using discourse analysis to this end is appropriate as it takes a political approach to the research process, and raises questions about whose interests are served and whose interest are marginalised by the discourses that gain hegemony and authority (Cosgrove & McHugh, 2008). Several studies have employed discourse analysis in exploring the construction of symptoms related to 'schizophrenia', such as delusions (Georgaca, 2000), paranoia (Harper, 1994) and hallucinations (McLaughlin,

1996), as well as the idea of psychopathology (Parker *et al.*, 1995). As Wetherell (1994) argued, the discursive examination of constructs such as ‘schizophrenia’ and other psychiatric categories moves them from being an explanatory resource (e.g. he is doing that because he is ‘schizophrenic’), to a topic that is worthy of being explored in itself (e.g. what interests are served by the concept of ‘schizophrenia’ in this context?). This is due to what Rose (1990) noted about language making ‘new sectors or reality thinkable and practicable’ (pp.105-106).

Discourse has been variously defined as ‘linguistic constructions’ (Thompson, 1988: 368) or ‘a group of ideas or patterned way of thinking which can be identified in textual and verbal communications, and can also be located in wider social structures’ (Lupton, 1992: 145) and as ‘a system of statements which constructs an object’ (Parker, 1992: 5). The former definition by Thompson has a more linguistic orientation while the two latter definitions owe more to poststructuralist thinking in discourse analysis, as exemplified by Foucault; these various definitions demonstrate that the definition of discourse reflects its theoretical underpinning (Cheek, 2004). In contrast to phenomenological methods such as interpretative phenomenological analysis, whose principle focus is on the individual’s experience (Smith, 2004), the use of discourse analysis aims to provide insight into the functioning of bodies of knowledge in their specific situated contexts with regard to the power effects of discourse on groups of people, without being able to claim generalizability to other contexts (Cheek, 1997). As Potter and Wetherell (1987) argued, the interest in discourse analysis is language in use, as opposed to language users; the units of analysis are texts or parts of texts rather than participants. However, if one is interested in particular aspects of discourse (such as the construction of the diagnosis of ‘schizophrenia’), the sample must be situated within a population whereby such instances of discourse will be available, such as counselling psychologists; ‘We do need to identify persons (or dyads or groups) or

sources that are likely to provide the discourse of interest, but we need to keep our attention on the type of discourse, not on the person who produces it' (Wood & Kroger, 2000: 78). As argued by Cheek (2004), a discourse consists of a set of common assumptions that are taken for granted as invisible or assumed. Discourse analysis was also the more appropriate approach when compared to other methodologies as the research aims to explore the construction of 'schizophrenia' as used within the everyday language of psychology (Boyle, 2002), and how counselling psychologists construct the diagnosis of 'schizophrenia', and the implications this construct may have for their work (Boyle, 1994).

Unlike other qualitative approaches, discourse analysis is not considered a coherent paradigm (Coyle, 2006) nor does it have a standardised set of methodological principles (Billig, 1987); instead it represents a broad theoretical approach that incorporates a multiplicity of theoretical assumptions and methodological techniques, which are all grounded within a social constructionist framework (Burr, 2003). However, particularly relevant to this research is the move from a purely relativist epistemology in discourse analysis to one of critical realism (e.g. Nightingale & Cromby, 1999; Sims-Schouten *et al.*, 2007). Within the field of discourse analysis two distinct approaches have emerged as the most dominant: discursive psychology and Foucauldian discourse analysis (FDA). Even though both approaches share a concern with the role of language, they come from different epistemological positions and address different sorts of research questions (Parker, 1997; Willig, 2007); these differences will be outlined below.

4.5 Discursive Psychology

Discursive psychology comes from the epistemological position that truth is 'always contingent or relative to some discursive and cultural frame of reference' (Wetherell, 2001:

392), which is known as relativism (e.g. Parker, 1997; Davies, 1998). Coyle (2007) stated that discursive psychology views language as a form of social action and its aim is to address the functions of talk and to consider how these functions are achieved. This approach is mostly associated with the work of Potter and Wetherell (1987) and Edwards and Potter (1992), and emerged from Potter and Wetherell's critique of cognitivism and the assumptions it made about the relationship between language and representation (Willig, 2007). This approach explores the discursive production of social realities, and acknowledges that there are no 'true' representations of reality from which to critique other versions (Sitz, 2008); in this sense language constantly constructs a version of 'reality' by actively producing meaning rather than reflecting it (Wittgenstein, 1975; Coyle, 2007).

Within discursive psychology, 'discursive practices' refer to the linguistic practices employed by the language user and 'action orientations' and 'rhetorical functions' refer to the social functions that certain discursive strategies might be oriented to and serve within a particular discursive context (Perry, 2007). As Willig (2009) pointed out, discursive psychologists are interested in 'discursive actions' and the consequences and functions they may have for the speaker: 'Psychological activities such as justification, rationalisation, categorisation, attribution, naming and blaming are understood as ways in which participants manage their interests' (p.96). As argued by Edwards and Potter (1992) rhetorical strategies appear to be factual to the speaker, particularly when the speaker has a stake in the outcome. On the basis of these concerns, discursive psychology is commonly conceptualised as a more 'micro' (Parker, 1997) approach to the analysis of linguistic material. Discursive psychology therefore challenges 'taken for granted' (Burr, 2003) notions in psychology such as the idea that language is a means of gaining access to an individual's psychological and social worlds (Coyle, 2007).

However, Nightingale and Cromby (1999, 2002) and Sims-Schouten and colleagues (2007) argue that the relativist position does not take into account extra-discursive factors such as embodiment, materiality and power, and that relativist accounts of social construction are compatible with ‘realism’ (e.g. Liebrucks, 2001). This type of argument has been accused of misrepresenting the relativist notion of discourse (e.g. Potter *et al.*, 1999; Edwards *et al.*, 1995) because as argued in Burr (2003):

‘Like Foucault, discursive psychologists are not denying the existence of a material world or that this materiality may have unavoidable consequences for people. But they are pointing out that, once we begin to *talk* [italics in original] about or otherwise signify or represent the material world we have entered the realm of discourse; and at that moment we have engaged in social constructionism’ (p.91).

In terms of developing a critical psychology (Fox *et al.*, 2009; Fox & Prilleltensky, 1997), because of the very relative nature of discursive psychology every reading of a text can be reduced into a free play of meaning where no critical position can be taken towards it, and even though a critical approach to psychology welcomes the relativizing of certain normative notions of human nature advanced by traditional psychology, the tendency to relativise moral critiques is resisted (Parker, 1997).

4.6 Foucauldian Discourse Analysis

FDA is concerned with language and the role it plays in the constitution of social and psychological life (Willig, 2007). FDA holds that discourses facilitate and limit, enable and constrain what can be said, by whom, where and when (Parker, 1992). Hence, dominant

discourses privilege versions of social reality that accord with and reinforce existing social structures and the networks of power relations associated with them. Analysts study subject positions (Davies & Harré, 1990), which are the availability of discursive resources within a culture and the implications that this carries for those living within that culture (Coyle, 2006); speakers position themselves and others by using such discourses tactically and are themselves positioned by the same discourses since certain linguistic discourses impose constraints on what can be said (Harper, 1999). FDA also pays attention to the relationship between discourse and institutions; discourses are not conceptualised simply as ways of speaking or writing, discourses are bound up with institutional practices – that is, with ways of organizing, regulating and administering social life. Thus, while discourses legitimate and reinforce existing social and institutional structures, these structures, in turn, also support and validate the discourses (Willig, 2007); this approach in discourse analysis is conceptualised more as a ‘macro’ (Parker, 1997) approach to the analysis of linguistic material.

Parker (1992) has argued that that some versions of discourse analysis suggest that discursive constructions are entirely independent of the material world, and that they attribute primacy to ideas as expressed in language, as opposed to matter, which may be manifested in structures that exist independently of what we may say or think about them. Parker advocates a ‘critical realist’ (e.g. Bhaskar, 1978, 1986) position which acknowledges that the knowledge we have of the world is mediated by, and constructed through, language, while also maintaining that there is a materiality which generates phenomena, versions of which we construct through language. Joseph and Roberts (2004) argued that ‘Critical realism offers an explanatory critique that moves from a criticism of certain ideas to a critique of the institutions and structures that produce them, thus pointing towards the need to understand, explain and perhaps transform such structures’ (p.3). Therefore, it is argued that discursive

constructions of what is deemed to be ‘reality’ are anchored in social and material structures, such as institutions and their practices. Parker’s position is that ‘discourse analysis needs to attend to the conditions which make the meanings of texts possible’ (p.28), or as Willig (1999) explains, there must be an analysis of the conditions (historical, social and economic) that give rise and/or make possible the accounts of participants and the discourses that constitute them: ‘Particular meanings are made possible by some conditions and not others’ (p.40). The critical realist epistemology argues for an ontological realism (Burr, 2003), but that this reality is reflected in the oppressive influences of social, political and historical factors: ‘The researcher’s role is both interactive and proactive, with the explicit goal of facilitating change and emancipation from restrictive social conditions. Values are an explicit component of the research endeavor and are based in sociocultural critique’ (Haverkamp & Young, 2007: 268).

However, there have been objections to this approach of discourse analysis, noticeably from Edwards and colleagues (1995), Gergen (2001a) and Speer (2007) who argue that material structures are always mediated through the realm of discourse (Burr, 2003); and that critical realists have no systematic method of distinguishing between the discursive and the non-discursive. This is exemplified by Gergen’s (2001a) question: ‘How should we answer questions about what is ‘independent of language’ save through language’ (p.425). Due to this the constructing factor which constitutes the one and not the other comes down to a choice driven by the researcher’s political standpoint (Sims-Schouten *et al.*, 2007). Also, FDA has been criticised for failing to attending sufficiently to the local interactional context of language (Willig, 2008), and as pointed out by Fairclough and colleagues (2004), the issue of causality remains a contentious issue.

4.7 Critical Discursive Psychology

For the sake of this research we will look at a third strand that has arisen out of the argument that the distinction between the two positions ‘should not be painted too sharply’ (Potter & Wetherell, 1995: 81). Wetherell (1998) has argued that the relativist approach and critical realist approach can be combined in order to look at different levels of discursive action and that one should not necessarily exclude the other. This synthesis, Wetherell (1998) and Edley (2001) argue, will allow for a more integrated approach to discourse analysis that can respond to criticisms of both discursive psychology and FDA. A critical discursive approach (Stevens & Harper, 2007; Edley & Wetherell, 2001; Edley & Wetherell, 1999; Wetherell, 1998) could be argued as being more appropriate for this research, for not only will the analysis consist of an examination of the local organisation of talk, but also the organisation of the broad, social and culturally resonant interpretative resources the participants draw upon (Edley & Wetherell, 2001). Edley and Wetherell point out that within this framework one could argue that on the one hand, the research will examine how talk is organised as social action in its immediate context, the subject positions in play and the rhetorical and interactional consequences of this organisation. On the other hand, the research assumes that talk (particularly about a issue related to the theory and practice of counselling psychology, such as diagnostic categories and the diagnosis of ‘schizophrenia’ itself) assumes regular patterns that reveal the shared sense-making resources of a sample, or which may be specific to a site, institution or characteristic of a broader social context and historical period. As Parker (1997) argued, a critical engagement with relativism and realism needs to address: ‘(a) how psychological facts are socially constructed; (b) how subjectivity is discursively reproduced within present social arrangements; and (c) how the underlying historical conditions emerged that gave rise to the psy-complex’ (p.296).

A critical discursive psychology therefore acknowledges the need to explore micro- and macro-levels of analytical concerns. While critical discursive psychology attends to the identification of discursive strategies and the exploration of rhetorical functions as advocated by discursive psychology, it also attends to the broader discourses that are utilised to produce a particular account (Perry, 2007); critical discursive psychology can thus be conceptualised as adopting a dual approach to the analysis of discourse that acknowledges that individuals are both the producers and the products of discourse (Edley & Wetherell, 1999).

Reflexive Summary 2: Choosing Critical Discursive Psychology

It has been argued that your choice of methodology is a tactical one (Harper, 1994) that is driven by the topic and audience of the research (Henwood & Pidgeon, 2002). Critical discursive psychology appealed to me as a method as it seemed to reflect the same epistemological tension inherent to counselling psychology, which in a sense is a struggle between relativism and realism. I am also cautious about dogmatic approaches in psychology, whether they be research methods or the application of ‘models’ of psychotherapy, and prefer a more open approach which views knowledge as an ongoing process rather than a fixed ideal. This may be seen as a non-commitment to a particular approach and a form of ‘fence sitting’, however, it was hoped that by employing a critical discursive approach, even with the difficulties inherent to it, the method would provide a broader and richer scope of the research topic, and not be dogged down by a method either being too pedantic, like discursive psychology, or too disconnected, like the Foucauldian approach.

4.8 Reflexivity

Reflexivity requires an acknowledgement of the researcher's contributions to the constructions of meanings throughout the research process, as well as an understanding of the impossibility of remaining outside one's own subject matter while conducting the research. As Harper (2003) argued, discourse analyses, like writing in general, are products of choices which the analyst makes within particular contexts with particular aims in mind. It urges us 'to explore the ways in which a researcher's involvement with a particular study influences, acts upon and informs such research' (Nightingale & Cromby, 1999: 228). As the research is approached from a social constructionist paradigm (Haverkamp & Young, 2007) one must consider that: 'Knowledge or meaning emerges through interaction between persons and is described as co-constructed; it cannot be observed directly but must be interpreted' (p.268). This co-construction will be interpreted by the author of the research. However, the author must also take into account the co-construction between the co-author and the author; research is regarded as a joint product of the participants, the research, and their relationship: it is co-constituted, and reflexive analysis offers a method where the researcher might continually evaluate the subjective responses, intersubjective dynamics and the research process itself (Finlay, 2002a). Reflexivity refers to the equal status of the researcher and the participant, as well as the accounts offered by each (Burr, 2003). Sherrard (1991) criticised discourse analysis studies by stating that not enough attention is paid to the use of reflexivity within them. She argued that more attention needs to be paid to the researcher's contribution to the discourse when they are taking part in the interaction as an interviewer; interviews, like conversations, are constructed by both the participants.

Reflexivity is often referred to as: 'the project of examining how the researcher and intersubjective elements impact on and transform research' (Finlay, 2003: 4). Gill (1995) argued that:

‘Discourse analysts should adopt a notion of reflexivity which stresses the need for the analyst to acknowledge their own commitments and to reflect critically upon them. By seeking to explain and justify the basis for their readings or analyses, discourse analysts become accountable for their interpretations and the social and political consequences of the interpretations’ (p.182).

Here Gill refers to the need of the author to reflect on the effects of reflexivity itself as opposed to just endless reflection. This ‘participatory mode of consciousness’ (Heshusius, 1994) in research adopts a more constructivist approach, which focuses more on the intersubjective nature of research as opposed to the management of subjectivity: ‘Qualitative researchers often use self-reflective journals, peer researchers, and follow-up ‘participant checks’ to assure that researcher subjectivity does not dominate and that participants’ perspectives are fairly represented’ (Morrow, 2007: 216).

4.9 Rationale

A research design is based on methodological assumptions that have their origins in the philosophical underpinning of a research approach (Manning, 1997). The rationale for using discourse analysis can be viewed through a combination of Potter’s (2003) and Parker’s (1992) foci respectively: (a) how specific actions and practices are linguistically done in particular settings; (b) how particular accounts of things are constructed and made to seem factual and objective; and (c) the examination and re-framing of psychological practice and psychological concepts in discursive terms; (d) the research is interested in exploring ‘a system of statements which constructs an object’ (Parker, 1992: 5); (e) within this epistemology, ‘schizophrenia’ is seen as being a construct that is constitutive of language;

and (f) the discursive examination of constructs such as ‘schizophrenia’ and other psychiatric categories moves them from being an explanatory resource, to a topic that is worthy of being explored in itself (Wetherell, 1994); as language is the primary means communicating phenomenological insights (Barritt *et al.*, 1983), this seemed the appropriate approach. Reality is not independent of human action, but is the product of interactions between individuals in specific historical and cultural environments (Georgaca, 2000), and language constructs how we think about and experience ourselves and our relationships with others (Crowe, 2000). The use of discourse analysis places the counselling psychologists’ constructs within a public and collective reality; discourse analysis does not imply that the views counselling psychologists’ have on the diagnosis of ‘schizophrenia’ and being willing to work with individuals diagnosed with ‘schizophrenia’ comes from the private space of the individual. Instead, the focus is on the public and collective reality, as constructed through the use of language; the examination concerns how individuals use language to construct versions of their world, and what is gained from the constructions (Coyle, 2007). Discourse analysis provides the conceptual framework needed for an analysis concerned with the construction of professional knowledge (Burr, 2003).

The reason for attempting to use a critical discursive approach is that it not only allows for the exploration of the constructions of the diagnosis of ‘schizophrenia’ as located within the talk of counselling psychologists, but it would also allow for a wider examination of the socio-political framework within which the counselling psychology profession is located. This relationship between talk and interest is a central topic in critical discursive psychology in that ‘the invocation of stake and interest is understood as a rhetorical strategy but not as a motivational explanation for rhetorical moves’ (Madill & Doherty, 1994: 269). In the context of this research interest will be referred to as the effects that certain accounts in

certain contexts serve particular ideological interests; this means moving beyond the text and entails a political commitment on the part of the researcher (Harper, 1999). In the same way that psychological research can not be interest free, neither can it be apolitical. As Parker (2007) argued, critical psychology does not want to make psychology political, it already is political. It was hoped that by adopting a critical discursive psychology approach for this research a novel and challenging way of understanding the concept of 'schizophrenia' would be allowed, and that by providing a varied account which focuses not only on the rhetorical strategies of individual speakers, but also on the ideological consequences of accounts, the implications for the theory and practice of counselling psychology would be more comprehensive.

5. Method

5.1 Introduction

This section will outline the method involved in conducting the research. It includes some demographics on the participants, ethics, procedure, data collection, data analysis and evaluative criteria. Because it is acknowledged that the research process shapes the object of inquiry, the role of the researcher needs to be included in the documentation (Willig, 2009). Therefore, this section will contain several ‘reflexive summaries’ about the actual data collection process.

5.2 Participants

The participants in this study were eight chartered counselling psychologists (See Table 1 for participant demographics of those involved). The participants had all completed BPS accredited courses in counselling psychology, and were working in the United Kingdom. The decision to use chartered counselling psychologists was informed by the research question (Willig, 2006) and the rationale was that qualified counselling psychologists were sufficiently socialised in their role as ‘counselling psychologists’ to draw upon the discursive resources available to them (Howkins & Ewens, 1999). The selection of counselling psychologists as participants for this research was crucial as it allowed for the exploration of a topic that has normally been considered out of the range of experience of counselling psychology practice: ‘Participants and documents for a qualitative study are not selected because they fulfill the representative requirements of statistical inference but because they can provide substantial contributions to filling out the structure and character of the experience under investigation’ (Polkinghorne, 2005: 139). Only counselling psychologists

who had direct experience of working with individuals diagnosed with ‘schizophrenia’ were included in the final analysis, and were representative of the whole sample group.

If one is interested in particular aspects of discourse (such as the construction of the diagnosis of ‘schizophrenia’), the sample must be situated within a population whereby such instances of discourse will be available, such as counselling psychologists; ‘We do need to identify persons (or dyads or groups) or sources that are likely to provide the discourse of interest, but we need to keep our attention on the type of discourse, not on the person who produces it’ (Wood & Kroger, 2000: 78). Deconstructing the talk of counselling psychologists may allow for an insight into their public and collective reality with regards to the diagnosis of ‘schizophrenia’, and how counselling psychologists use language to construct versions of their world, and what is gained from the constructions (Coyle, 2007). Turpin and colleagues (1997) argued that five participants was the minimum for a postgraduate thesis using discourse analysis, and that the number of participants is guided by time and pragmatic considerations (Willig, 2006). It is the case with discourse analysis that it is the richness of the data that is of primary importance, as opposed to the strict number of participants (Morse, 2000). For the sake of this research, a variety of counselling psychologists would provide a richer description of the topic being researched; ‘Within discourse analysis sampling different groups that participate within a given discourse can illuminate the ways in which participants appeal to external discourses and identify their influence on the discourse under study’ (Starks & Brown Trinidad, 2007: 1375). It was hoped that the exploration of counselling psychologists’ ‘talk’ about the diagnosis of ‘schizophrenia’ would open up questions about their epistemological positions, and allow access to the language used by counselling psychologists to maintain those positions.

<i>Place of work</i>	<i>Gender</i>	<i>Ethnicity</i>
NHS	Female	Asian British
NHS	Female	White British
Unemployed	Male	White British
NHS	Female	White British
NHS	Male	White British
NHS	Female	White British
NHS	Male	White British
Private sector mental health	Female	White British

Table 1. Participant Demographics

5.3 Ethics

Ethics was obtained through the university's research board before commencing data collection. This process required submitting an ethics application form and reviewing amendments until a satisfactory version had been completed. As the interviews consisted of counselling psychologists' views on the diagnosis of 'schizophrenia' it was paramount to consider that in qualitative enquiry the human interaction affects the researcher and participants, and that the knowledge that is produced might affect an established understanding of an epistemological position (Brinkmann & Kvale, 2008). One must always consider that when discussing topics regarding an epistemological stance some sensitive issues may arise, and participants may feel challenged on their basic assumptions. It was the researcher's intention to attempt to navigate the interview process through non-maleficence (Bond, 2007) and ethical attunement (Brinkmann & Kvale, 2008) using the *Division of Counselling Psychology's Professional Practice Guidelines* (BPS, 2006b) and the BPS's *Code of Ethics and Conduct* (BPS, 2006a). To ensure further ethical practice, the use of reflexivity in the research will serve as documented evidence that the actual research process was carried out as ethically as possible (Guillemin & Gillam, 2004), and the participants themselves were able to provide feedback on how the ethical procedures were conducted

during their involvement. This was done through a debriefing at the end of the interview and a signed agreement that the participant agreed that the research had been conducted ethically. The identities of the participants were anonymised and the data obtained from the interviews as well as the recordings themselves were kept in safe storage according to the *Division of Counselling Psychology's Guidelines on Confidentiality and Record Keeping* (BPS, 2002).

5.4 Procedure

The participants were recruited through word of mouth, snowballing, the distribution of poster and flyers and through an announcement in the *Division of Counselling Psychology's* announcement newsletter (see *Appendix A* for a sample of a recruitment information sheet). After initial contact the participants were informed of the procedure and the prospective length of the interview. A suitable time and place was then arranged in order to conduct the interviews. When possible, the interviews took place both at the participants' placements or places of work, and if this was not possible to arrange the interviewer would arrange for a suitable location in order to conduct the interviews. All interview responses were held confidential in order to protect the views of the participants.

Reflexive Summary 3: Recruitment and Selection of Participants

Initial recruits came forward through word of mouth and after I had attended a talk by the BPS on counselling psychology and psychosis. Once a potential participant had contacted me I sent them an outline of the research and the ethical approval and attempted to arrange an appropriate time and place. I further contacted the *Division of Counselling Psychology's* communications lead to send out a brief description of the research to be included in the

fortnightly newsletter that goes out to members of the division by email. To my surprise there was great interest in the research with eight individuals contacting me with a willingness to participate. The procedure was repeated again by sending out an acknowledgement and information about the research, as well as an inquiry about when would be an appropriate time for the interview. All of the participants who contacted me had experiences of working with this client group, which added the dimension of being able to explore some of the participants' experiences as well. This need to situate the sample in discourse analysis is necessary, but as Craven and Coyle remind us: 'no matter how much detail is provided, these 'descriptions' can never capture all the potential positions from which participants may speak in the data' (p.237). Elliott and colleagues (1999) advised that the researcher should describe in as much detail the life circumstances of the participants in order to aid the reader in judging the range of people and situations to which the findings may be relevant. This will be attempted in this research without breaching confidentiality.

5.5 Data Collection

Semi-structured interviews were used as they are well suited for the exploration of complex issues, and allows for the use of probing for more information and clarification of answers (Barriball & While, 1994), as well as being a method use for interviews intended for discourse analysis (e.g. Sitz, 2008; Mills & Pawson, 2006). As Potter (1996) noted, the use of interviews is not intended to get to the 'truth' of claims, but are seen as an arena where the culturally available discourse and rhetorical strategies will be at work. However, as raised by Speer (2002), the danger of using 'contrived data' in discourse analysis is that: 'Since these approaches treat respondents, not as passive containers of knowledge, but as active participants within the research process who construct, rather than report on reality, 'bias'

is regarded as both unavoidable and pervasive' (p.511). This notion will be elaborated further in the reflexive summary below.

The interviewer had four questions prepared beginning with an initial question to query whether the participant (i) had any previous experience of working with an individual or individuals with a diagnosis of 'schizophrenia'. If they did they would be asked, without breaking confidentiality, to discuss some of their experiences in doing so. If the participant had not had any experiences, the interview moved to the next question which asked (ii) if they would consider working with an individual or individuals with a diagnosis of 'schizophrenia'. All participants were asked (iii) whether they believed their training and practice had prepared them to work with an individual or individuals with or a diagnosis of 'schizophrenia' as well as if there (iv) were any ways the diagnosis of 'schizophrenia' might affect the way they worked with a client. Before finishing each participant was asked whether there was anything that they thought had not been covered in the interview, and if so to please take some time to explore those matters. The interviewer would use probes, open-ended questions and paraphrasing as tools to facilitate the conversation and to ensure that a comprehensive understanding of the participants' perspectives was obtained. Kvale (1996: 133-135) outlined types of questions that were used in the interviews, including: *introducing questions*, which aim to initiate the conversation of a topic by soliciting descriptions; *follow-up questions* that aid in facilitating further exploration and elaboration; *probing questions*, which ask for deeper description and content; *direct questions*, which usually followed the introducing questions when the participants had provided what they believed were the central aspects of the topic under investigation; *indirect questions* were more projective in nature and inquired the way in which other individuals may view the topic under study; *structuring questions* were used in order to introduce new questions in the interview schedule once a

topic had been exhausted; and finally, *interpreting questions* were used to aid the flow in the interview and to help clarify meaning, understanding of content and the interviewee's interpretations.

Each interview lasted between 45 minutes and one hour and was preceded by a briefing, which included signing a consent form (see *Appendix B* for a consent form) and followed by a debriefing. Participants were asked to sign a declaration during the debriefing to ensure that they thought that the research process had been conducted ethically (e.g. Haverkamp, 2005, see *Appendix C* for a debriefing form including an ethical declaration).

Reflexive Summary 4: Conducting the Interviews

In accordance with the *Professional Practice Guidelines* of the *Division of Counselling Psychology* (2006) section 2.5 *The practitioner as researcher* (p.6) I aimed for congruence between the model of research, its design and implementation and the values expressed in counselling psychology. However, as argued by Harper (1999) interviews reflect a power imbalance, whereby one person asks the questions and the other has to answer. Potter and Hepburn (2005) identified four difficulties that need to be taken into consideration when conducting interviews, these included: *flooding the interview with a social science agenda and categories* (i.e. the set of concerns and orientations that are central to the researcher); *interviewer's and interviewee's footing* (i.e. the convoluted and variable speaking positions of the interviewer and the interviewee); *interviewer's and interviewee's stake and interest* (i.e. an attempt to be aware of the multitude of stakes and interest of both the interviewer and the interviewee, and being able to discern them in the analysis; and, *reproduction of*

cognitivism (i.e. the privileging of conceptual rumination over action and the treatment of cognitive language as descriptive).

The difficulties of conducting an interview when using discourse analysis as your approach has been discussed elsewhere (e.g. Speer, 2002; Potter & Hepburn, 2005), however, it seemed the most pragmatic way of collecting data in relation to the research. Perhaps one of the biggest concerns I had as the researcher was not trying to impose my own agenda on the participant; however, this almost appeared impossible because by the very nature of conducting the interview this was already being done. There were also concerns about getting ‘relevant material’ for analysis. I found that thinking in this way seemed related to my concerns about the methodology itself, for example, how can I possibly know that I have any ‘relevant material’ for analysis until after I have collected the data? As a relative novice to discourse analysis, I was comforted to see that other researchers had encountered the same difficulties (see Harper *et al.*, 2008).

5.6 Data Analysis

The analysis of qualitative data is conducted with the intention of summarising and bringing as much significant meaning as possible to the interviews experienced by the researcher and the participants (Jensen, 2006). Researchers warn against the systematising of discourse analysis as a ‘method’, and should instead be considered a sensitivity to language with a scholarly focus (e.g. Perry, 2007), however; ‘it is possible to indicate stages that might be usefully passed through in order to identify contradictions, constructions and functions of language’ (Parker, 2004: 151). The steps of analysis of the discourse will be informed by Willig’s (2006) procedural guidelines, and the transcription conventions will follow those set

out by Parker (1992). The transcription conventions are used in order to capture the pacing, intonation and emphasis in the talk present on the recordings (Polkinghorne, 2005).

The process involved transcribing and noting intonations and pauses of the speakers (see *Appendix D* for transcription conventions), which was then followed by several readings of the transcripts that allowed for an initial engagement with the research aims. The transcription process itself is considered a reflexive act as argued by Bucholtz (2000): ‘The responsible practice of transcription...requires the transcriber's cognizance of her or his own role in the creation of the text and the ideological implications of the resultant product’ (p.1440). So following Bucholtz’s argument it has been the researcher’s understanding from the beginning of the project that the method used and all activity involved in ‘applying’ the method can not be separated from the epistemological, ontological and theoretical assumptions of the researcher who developed the research project (Alvesson & Sköldbberg, 2009).

The first stage of analysis involved the development of a familiarity with the data (Mitchell, 2009), whereby an intimacy was developed over many months of coding for the content analysis until distinct discourses were recognised (see *Appendix E* for a sample transcript). This process allowed for the recognition of these discourses as ‘systematic ways of talking about topics’ (Harper, 1995). The second stage involved what Potter and Wetherell (1987) referred to as a focus on the relevant material. The sections of text that were selected comprised those that were demonstrative of consistent and variable patterns of language use in the construct of ‘schizophrenia’. A form of thematic coding of surface content was used to organise the data into thematic units that could then be subject to more specific discourse analysis. The themes were then conceptualised as representing interpretative repertoires.

The implications these repertoires have for the profession of counselling psychology in relation to the diagnosis of 'schizophrenia' were considered in relation to the broader social and institutional frameworks within which the data is produced (Perry, 2007). The analysis thus attempted to move between micro and macro levels of concern (e.g. Wetherell, 1998; Walton *et al.*, 2004; Edley & Wetherell, 2001). The third and final stage consisted of delineating and describing, as clearly as possible, the discourses identified. This process included describing the systematic ways of talking that was representative of each discourse and 'identifying and analysing the discursive content and devices that appeared to be operating, describing variations in expression of the discourses across ratings categories where applicable, and assembling these components into a coherent account' (Mitchell, 2009: 1216).

Reflexive Summary 5: Conducting the Analysis

Conducting the analysis proved one of the most difficult aspects of the research in a variety of ways. One, as highlighted by Parker and Burman (1993) was determining the different discourses that were at work, and as argued by Stenner (1993) in the same volume, that there are ethical problems in having power and control over other's words. Stainton Rogers (1991) commented that 'in order to weave my story, I must inevitably do violence to the ideas and understandings as they were originally expressed' (p.10), and throughout the analysis this was a concern that was ever-present. However, the idea of acknowledging this particular difficulty is a part of the reflexive process, and by adding the caveat that this is the researcher's interpretation and that others may view it differently helps work towards an appreciation of the problem. This raised other questions regarding the nature of discourse

analysis as an approach to analysis. For example, the positioning of discourse analysis outside 'mainstream' psychological approaches was one of the aspects of discourse analysis that drew me to it, but at the same time it created some anxiety regarding how to approach discourse analysis and worries about its potential for abuse. It was hoped that I would not do 'violence' to the words of the participants, but there was an element of concern that the publication of the material could be read and interpreted in unpredictable ways (Prilleltensky & Nelson, 2002). Also, by including the earlier section on introducing the author, it is hoped that the reader is provided with an understanding of the contributions made by the author to the constructions present in the research (Blommaert, 1997).

5.7 Evaluative Criteria

In discourse analysis the use of reliability and validity are seen as inappropriate means of evaluating the research, as these frameworks are based on the assumptions of scientific objectivity, which assume that the researcher and the researched are independent of each other (Madill *et al.*, 2000; Coyle, 2007). Instead the use of documentation to chart research development and the inclusion of the participants in the research process are seen as dependable methods in qualitative research (Golafshani, 2003).

However, should a more structured method of evaluation be needed by the reader Yardley (2000) outlined four criteria that would be more appropriate for the evaluation of qualitative research: *sensitivity to context* (i.e. an acknowledgement of the context of the research and its commitment to epistemological, socio-cultural and ethical factors); *commitment* (i.e. the length of engagement with the research topic and the level of competence in the employed research method); *rigour* (i.e. the completeness of the collected data, analysis and reporting of results); *transparency* (i.e. all levels of the research process are

documented and disclosed, including the researcher's subjectivity and its potential influences on the research process); *coherence* (i.e. the 'fit' between then research question(s) and the philosophical perspective adopted); and, *impact and importance* (i.e. providing new ways of thinking about the research topic under investigation and its potential contribution to the field). Since discourse analysis does not possess any structured method to its analysis, one of the paramount criteria might be transparency, which Yardley argued 'can be achieved by detailing every aspect of the data collection process and the rules used to code data, by presenting excerpts of the textual data in which the readers can themselves discern the patterns identified by the analysis, and/or by making detailed records of the data' (p.222). The reader of this research is welcomed to be attentive to these criteria when reviewing the analysis.

Research criteria specific to discourse analysis have been outlined by Antaki and colleagues (2003), which consist of six analytic shortcomings that are commonly encountered in discourse analysis. These include: *under-analysis through summary* (i.e. not going into enough analytic detail by just providing summaries of the text in the analyst's own words); *under-analysis through taking sides* (i.e. the analyst takes a moral, political or person stance towards the text); *under-analysis through over-quotation or through isolated quotation* (i.e. the use of quotations is substituted for analysis); *the circular discovery of discourses and mental constructs* (i.e. the identification of discourses or constructs that replicate what they purport to critique); *false survey* (i.e. extrapolating one's data to the world at large); and, *under-analysis through spotting* (i.e. the identification of discursive features is used as a substitute for analysis). Burman (2004) offered three additional criteria, consisting of: *under-analysis through uncontested readings* (i.e. only providing a unitary discourse and not presenting the competing discourses); *under-analysis through decontextualisation* (i.e. the

need to situate the text and one's analysis of the text socially, historically, culturally and politically); and, *under-analysis through not having a question* (i.e. ensure that the analyst has a clear question which specifies why the analysis is being conducted). It was the researcher's intention to try to avoid these shortcomings as much as possible.

6. Results

6.1 Introduction

An attempt has been made to identify in the text the three main concepts in critical discursive psychology as identified by Edley (2008), namely: *interpretative repertoires*, *ideological dilemmas* and *subject positions*. These concepts will be introduced and will be followed by their examples as located in the text by the author. It is worth noting, however, that these have been interpreted by the author as being so, and the reader may view these differently. Also, due to limitations there may be additional examples present in the text that could not be included; this will be further elaborated upon in the following section. What will be attempted is to make reference to other discourse analysis research and analytical observations, which as argued by Nikander (2008), helps give ‘credit’ to earlier findings as well as support the analytic choices made, and also forms a base from which further empirical observations can be made.

The first stage is to identify some of the repertoires and subject positions located in the talk. The term interpretative repertoires was initially developed by Gilbert and Mulkay (1984) and later imported into social psychology by Potter and Wetherell (1987). Interpretative repertoires are considered ‘relatively coherent ways of talking about objects and events in the world. In discourse analytical terms, they are the “building blocks of conversation”, a range of linguistic resources that can be drawn upon and utilised in the course of everyday interaction’ (Edley, 2008: 198). Edley compares interpretative repertoires to books on the shelves of a public library, which are permanently available for borrowing. For the sake of this research the interpretative repertoires were first identified and drew upon positioning theory (Davies & Harré, 1990). Subject positions are defined as ‘locations’

within a conversation, they are identities made relevant by specific ways of talking, and because those ways of talking can change both within and between conversations (for example as different discourses or interpretative repertoires are employed) then, in some ways, so too do the identities of the speakers (Edley, 2008). As argued by Parker (1997), interpretative repertoires are used in both discursive and Foucauldian traditions of discourse analysis. In Table 2 is a summary of discourses encountered in the text, which will be discussed below.

6.2 Repertoires

The repertoires that have been identified for discussion will be outlined below with a brief summary and analysis, and will be explored further in the next section with regards to implications. Willig (2009) argued that it makes sense for the analysis and discussion sections to be combined in discourse analysis, however, for the sake of this research they will be kept separate for clarity.

<i>Discourses</i>
6.3 Meeting the individual
6.3.1 Relating to the individual's experience
6.3.2 The therapeutic relationship – the contrarian subject position
6.3.3 Normalising the experience – the egalitarian subject position
6.4 Phenomenology and empiricism
6.4.1 The hybrid of counselling psychology as ideological dilemma
6.5 The power of the institution
6.5.1 The professional organisation as disabling
6.5.2 The professional organisation as enabling
6.5.3 Training as disabling
6.5.4 Training as enabling

Table 2. Discourses relating to the diagnosis of 'schizophrenia'

6.3 Meeting the individual

Many of the participants resorted to talk about being able to meet the individual on a certain level; however, this was achieved through various ways. This is a position which might be expected from counselling psychologists, considering their philosophical value base, however, an interesting finding was how they used this to position themselves differently from other mental health professionals, in particular psychiatrists and clinical psychologists. This may be, as argued by Harré and colleagues (2009), an example of conflict positioned on a local moral landscape and also achieved through forms of Goffman's (1981) footings, which is the speaker's 'alignment, or set, or stance, or posture, or projected self' (p.128).

6.3.1 Relating to the individual's experience

As argued by Woolfe (1990), one of the critical characteristics of counselling psychology, as it has positioned itself in the literature, is its emphasis on the phenomenological: 'One of the primary contributions which counselling psychology has to offer psychologists is the value it places on the subjective experience of its clients. The sharing of this inner reality helps to cement the relationship between client and helper and acknowledges the importance of each individual's construal of life experiences' (p.532). Understandably, Lane and Corrie (2006) also share similar discourse when they stated that the uniqueness of counselling has as its core a 'respect for the personal, subjective experience of the client over and above notions of diagnosis, assessment and treatment' (p.17). This is an approach which has been argued elsewhere, such as in relation to 'delusions' (e.g. Harper, 2004), where clients' delusional talk is not just seen as empty speech acts (Berrios, 1991). This discourse was present in one way or another in almost all of the participants' talk and will be examined below.

7BT

- 1 **Int:** So it's very sort of /erm/, I guess, context based or something like you're
2 saying (2) where these voices come from, from the individual and how they relate to
3 them, so it's very much looking at it that way as opposed to just looking at it as a, as
4 a, (1) as some form of pathology?
- 5 **Par:** YES. >I mean, certainly that's the approach that came across in the group (.)
6 and then that's certainly the approach I've then taken< kind of individually (.h) is to
7 try to think about the voices as being a manifestation of something (2) as opposed to it
8 being a symptom that needs to be got rid of

The researcher follows up a previous turn with a clarification. However, it seems like responsibility for the account is handed over in lines 1 and 2 by saying 'or something like you're saying' by the researcher that may seem accusatory (e.g. Heritage, 2002), which in turn leads to the participant taking a more defensive stance in line 5. Also, one could argue that the researcher is presenting the participant with a 'yes-no interrogative' (Raymond, 2003), which in turn leads what has already been established (that the participant looks at the meaning of voices) into 'type-confirming' (Speer, 2007), which in turn leads to the statement that 'that's certainly the approach I've taken kind of individually' (line 6). She also states that she thinks about the voices as being a manifestation of 'something' (line 7), which gives an indication that she is reluctant to say what it is, but does acknowledge that whatever the manifestation is it should not 'be got rid of' (line 8). Her speech starts with an exclamation of 'YES' in line 5 and her speech is noticeably faster in line 5 and half of line 6, until she reaches 'kind of individually' (line 6) which is when her talk becomes more personal as she begins talking about her own approach. It seems as if she is more cautious when broaching

her own approach rather than some others, and that the use of ‘kind of’ (line 6) may indicate a sense of uncertainty.

23A

- 1 **Par:** And I think it’s (1) very much been looking at, kind of, the meaning of their
2 experiences of the psychosis, what does it mean for them (.) and their relationships (.)
3 with, say, voices /erm/ and kind of understanding that, so, yeah, I think (1) >yeah, you
4 have to kind of approach it on many different levels<, I think

Similarly, 23A refers to the ‘meaning of their experiences’ (lines 1-2), and while it still alludes to an attempt at understanding the individual’s subjectivity, it still sets up the boundary between the counselling psychologist as the speaker and the other as the individual diagnosed with ‘schizophrenia’, or as argued by Pilgrim (2000), a dichotomy between the sick and the well. This is particularly evident in the use of ‘their’ (line 1). 23A also refers to approaching ‘it’ on ‘many different levels’ (line 4), which is an example of reification, or the ‘thingification’ (Tillich, 1988), of the ‘schizophrenic’ experience (e.g. Szasz, 1974; Boyle, 2005). 23A also uses ‘kind of’ three times in this extract (lines 1, 3 and 4). Again there is a sense of uncertainty surrounding the exploration of meaning of individuals’ experiences in relation to psychosis, as well as an understanding of those experiences and how to ‘approach’ (line 4) those experiences.

D71

- 1 **Par:** It’s just, it’s really unthinking (.) I think and obviously that’s part of our, our
2 role or part of how I perceive our role as psychologists is to actually to stop (.) (h)
3 and to think (.) and to be a little bit more=and to you know, kind of bring the human

4 and the person:n (1) into, into the room, into our work and bring parts of ourselves in

D71 is arguing for psychologists to take a more ‘thinking’ role as opposed to an ‘unthinking’ one (line 1). D71 refers to the assumptions we all make without ‘using our heads’ as such and that we need to ‘look before we leap’. He argues that this is done by bringing ‘the human and person into the room, into our work’ (lines 3-4) and bringing parts of ourselves in to the room and using ourselves in the therapeutic relationship. This is also what Woolfe (1990) argues when he says: ‘the more that the self of the therapist is conceived as an active ingredient in the counselling process, the more incumbent it becomes on counsellors to develop the level of understanding of their own psychological processes’ (p.532).

F1P

1 **Par:** You know, and I’ve had so many clients say ‘gosh, you really understand me’,
2 because (1) what you’re not doing is directly challenging some of the delusional
3 beliefs (.) or thought, because there’s no point, you know {laughs} you’re not going
4 to get anywhere that way. But then going beyond it to listen to the distress and look
5 for the meaning behind it (.h) and helping that person to understand themselves better,
6 (2) kind of quite often you’re the person to be having those sorts of conversations and
7 (.) >the first person to allow that<, allow that client to be themselves I guess, you
8 know /erm/ (.hh) and quite often nobody sits and talks {laughs} with the clients about
9 distress, you know, how distressing (.) it is to be hearing these voices all the time (.hh)
10 and so because of that you’re building up this therapeutic relationship

F1P is referring to an implicit understanding she has, as a counselling psychologist, in approaching client difficulties. This is reiterated through a verbal confirmation from the

client and by presenting them as an active voice, by stating that ‘gosh, you really understand me’ (line 1), which implies a surprise reaction that she has taken the route normally followed in approaching client difficulties. She then refers to ‘going beyond it’ (line 4), which seems to reference the symptoms of ‘schizophrenia’, again as a reified concept, and for the ‘meaning behind it’ (lines 4-5), which takes the position that she can understand the meaning behind the client’s experience. She concludes this by stating that by relating to the client’s experience in this way the client is allowed to ‘be themselves’ (line 7) for the first time. Because she engages in this type of transaction with the client a therapeutic relationship is built, suggesting a causal relationship between them.

T3R

- 1 **Par:** And to engage with the, with the (1) say hallucinatory experiences or the
- 2 beliefs and to talk about them [**Int:** Yeah, yeah] (2) because I think if I cast my mind
- 3 back maybe (1) twenty years when I was an assistant psychologist, it was quite a
- 4 feeling of, you know, let’s not engage with some of those /erm/ (1) beliefs or thoughts
- 5 because it just (.) encourages him or whatever

T3R is taking a relative position, whereby a historical condition is set in relation to today. He argues that there is a historical progression from not wanting to relate to the individual’s experience to relating to them as an encouragement, and that this is seen as a progressive act. As argued by Harris (2009), the role of ‘history’ in psychology can be used to subvert the status quo and lead from a ‘presentist’ or ‘celebratory’ version to a ‘revisionist’ one. However, in the case of T3R, he appears to be doing the opposite, and presents the status quo as a demonstrable improvement on the past.

VB2

1 **Par:** His background was horrendous, he'd been so abandoned so many times in
2 his life and the staff were repeating (.) the process (.hh) and effectively his team who
3 were trying to get him out of the hospital were doing the same thing. They were
4 saying 'He can't be helped' [**Int:** Mmm] and what I was saying to him was 'Let's try
5 and make it different. Let's try and make this experience different'. So I worked on
6 his relationship with me. That was the first thing that I worked on, that's all we
7 worked on for half an hour. I'd be respectful to him. I'd treat him like a human being
8 (.hh) he woul:d (.) kind of (.) bring other stuff into the sessions and I'd say 'You're
9 not being respectful to me' so it was all just about how to relate to another person

VB2 adopts what appears to be an interpretative approach in her extreme case formulation (Pomerantz, 1986), which is a rhetorical feature that increases the persuasive power of an account (Walton, 2007). By appealing to what seems to be a psychodynamic interpretation of this individual's background, by saying it was 'horrendous' (line 1) and that he had been 'abandoned so many times' (line 1), she appears to try to make her account more persuasive by relating it to theory from the psy-complex (Parker, 1999c). Perhaps this is a way to make the account more persuasive to the researcher as a fellow counselling psychologist by appealing to a 'psychological' discourse which is familiar. Similar to F1P above, VB2 positions herself as an individual who is 'different' (line 5), and by doing so opens up a channel with a client which has never been there before. By doing this she also positions herself in relation to other members of her team who argue that 'He can't be helped' (line 4) and therefore adopt a dismissive attitude towards the client's experiences. She says that by working on the relationship through a process of 'respectful' (line 7) engagement she was able to 'relate' (line 9) to the other person.

6.3.2 The therapeutic relationship – the contrarian subject position

As argued by Gillies (2010), counselling psychologists view the therapeutic relationship as being central to the therapeutic endeavour and is positioned in relation to the client as something to engage in rather than do to. The therapeutic relationship is one of the most pertinent discourses in counselling psychology literature and talk, and often talk about the therapeutic relationship is used as a *raison d'être* for counselling psychology and something which makes it unique, while at the same time positioning itself as different from other fields of applied psychology, such as clinical psychology (e.g. Pugh & Coyle, 2000).

7BT

- 1 **Par:** >Which I guess is very different to your psychiatric view of things<, you
- 2 know, which is °medication to suppress the thoughts, to get rid of°, whereas actually I
- 3 was taking a more relationship style with things

Here the relationship is positioned as an alternative to the psychiatric system, which is accused of using medication to suppress the individual's thoughts. This suggests a form of oppressive practice and instead advocates a more 'ethical' rather than 'technological' approach (Bracken & Thomas, 2001, see also Keen, 1997). The word 'relationship' (line 3) is emphasised in order to give it more dominance when compared to the surrounding talk, the reference to the use of medication is lower in tone (line 2), which almost appears to give the sentence a shameful feeling. These contrasting ways of talking positions the therapeutic relationship as something to be proud of, while talk of medication appears to invite shame. This may be an example of Goffman's (1981) multiple activity footings, whereby the speaker moves the relational system (e.g. more relationship style with things, line 3) to the foreground

and the psychiatric system to the background (e.g. >Which I guess is very different to your psychiatric view of things<, you know, which is °medication to suppress the thoughts, to get rid of°, lines 1-2). This demonstrates what Goffman (1981) argued was a position which ‘is established by the words that are spoken, someone whose beliefs have been, someone who is committed to the words they say’ (p.144). However, as discussed previously, the *way* in which she speaks, and how she lowers and increases her tone, also indicates that *what* she is saying may in some way be forbidden considering the context she is speaking within.

23A – Extract 1

- 1 **Par:** >And the therapeutic relationship is just huge, I mean, I think it’s hugely
2 important< (.h) kind of learned very much at the beginning that if you jump in with
3 technique, you can absolutely lose someone [**Int:** Mmm] and particularly, I think,
4 with this client group /erm/

23A – Extract 2

- 1 **Par:** I think you can ruin things and (.h) I think engagement in building that
2 relationship with someone is so important [**Int:** Mmm], and I’ve often just put all of
3 that (.) technique aside sometimes and just (.) got to know them as a person, you
4 know, think about (.), yeah, just little aspects of their life, you know, what they enjoy
5 doing, if they’ve got, you know, interests and that kind of stuff before you go
6 anywhere near, kind of, therapy {laughs}, if you like, type, you know

23A says that before jumping in with technique we must consider the relationship, and that it is particularly dangerous because you may ‘lose someone’ (Extract 1, line 3) if you do. She also gives a particular emphasis to the client group with a diagnosis of ‘schizophrenia’,

suggesting that there is a difference between this client group and others. She continues by talking about putting the ‘technique aside’ (Extract 2, line 2), but only ‘sometimes’ (Extract 2, line 2) and get to know them as a person. However, this appears to contradict earlier talk (with a strong emphasis) about the relationship being ‘huge’ (Extract 1, line 1), and technique coming second.

D71

- 1 **Par:** You know that’s what relationship are about and that relationship is perhaps
2 more real in some respects, you know, people maybe haven’t had those kinds of
3 conversations, maybe they’ve (1) been silenced, you know, °and maybe they’ve had
4 traumatic abuse of relationships°, (.hh) wonky emotional interactions, you know,
5 where people haven’t been able to communicate in an open transparent kind of
6 manner so I suppose I’m doing, you know, if you were to formalise it, there’s a lot of
7 modelling that goes on about healthy communication and ways of being with people.
8 But it’s, you know, I don’t want to sully that or make that sound as though that’s a
9 technique because it isn’t, that’s just something that emerges and that is real in the
10 room. Maybe there is a way of, of formalising and putting it in textbooks, that’s fine

Taking the position of the relationship is referred here to as a ‘conversation’ (line 2), which is in opposition to the notion of being ‘silenced’ (line 3). This is positioned as an alternative to technique and is formulated more as ‘something’ (line 9) that emerges in the room which is ‘real’ (line 9). Technologizing this seems allowed as if that something can be formalised and put in ‘textbooks’, the something may reach a wider audience. D71 also presents a two-sided argument (Abell & Stokoe, 1999), whereby he begins by saying that the relationship is something which emerges as something ‘real’ (line 2) between people, and then resorts to the

idea of formalising the relationship and putting it in ‘textbooks’. This appears to move the idea of the relationship with individuals diagnosed with ‘schizophrenia’ from a relational process to a reified one which can be distributed among, for example students and other clinicians, through the medium of, in this case, textbooks. Also the use of the word ‘healthy’ (line 7) suggests that there is knowledge about what healthy is, and by implication this appears to suggest that client communication is not healthy.

6.3.3 Normalizing the experience – the egalitarian subject position

The Division of Counselling Psychology’s (2006) practice guidelines states that counselling psychology seeks ‘to know empathically and to respect first person accounts as valid in their own terms; to elucidate, interpret and negotiate between perceptions and world views but not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing’ (pp.1-2). This position is related to counselling psychology’s valuing of subjective experiences as an alternative to the form of ‘psychopathology’ that values classification and categorisation (e.g. Milton *et al.*, 2010).

7BT

- 1 **Par:** Getting a sense of what these voices mean and trying to derive a meaning, as
- 2 opposed to just seeing them as, you know, these, these kind of voices that need to be
- 3 got rid of↑ [**Int:** Mm] or:r, you know (3) I just (1) well, I suppose they are
- 4 dysfunctional in some way but actually, kind of, more looking at things in a °more,
- 5 kind of, /erm/ (2) derivative (1) sense, (1) thinking far more about trying to
- 6 understand voices and where they come from and what they mean to the individual°
- 7 [**Int:** Yeah] was what I felt I could bring from the OCD work with that, kind of, [**Int:**
- 8 Yeah] >it’s not so much the content< [**Int:** Yeah], it’s actually the meaning you

- 9 ascribe to that, and that's what causes distress and using that same [**Int:** Yeah, yeah]
10 parallel then in voices with the group

7BT is referring to meaning and trying to derive a meaning from what voices mean to the client, and positions herself in the role of walking along with the client as a sense of understanding. However, she refers to the 'dysfunctional' (line 4) nature of voices, which places the client as the other and establishes the division between well and unwell (Milton *et al.*, 2010). This contradicts her talk about understanding or normalizing the client's experiences. There appears to be areas of sensitivity (Burman, 1996) in her talk, particularly in lines 3 and 5, where the talk includes loaded words such as 'dysfunctional' (line 4) and 'derivative' (line 5). There appears to a contradiction or a conflict between what she initially states in lines 1 and 2 (e.g. Potter & Wetherell, 1987).

23A

- 1 **Par:** I don't think 'enjoy' is the right word, but (.) I think meeting such a range of
2 (.h) maybe (.) different people but kind of, trying to make sense of these experiences
3 which I think are almost (1) quite creative, I don't know, ways of the mind coping
4 with their life, you know, and I think people have had such terrible experiences but
5 somehow, you know, the kind of psychosis is somehow is, kind of (2) the way of,
6 kind of, coping with those, you know, and it's a way of (1)=and then trying to
7 understand that and finding ways (.h) to help them to get on with their life but maybe
8 still have these experiences [**Int:** Mmm]

23A begins her talk by issuing a disclaimer (Hewitt & Stokes, 1975), which is a verbal device that anticipates potentially negative attributions, in line 1 by saying 'I don't think 'enjoy' is

the right word, but (.)' . The subject of normalizing is then done by looking at the experiences as a 'creative' (line 3) adaption to 'such terrible experiences' and as a means of 'coping' (lines 3 and 6). This can again be seen as an example of an extreme case formulation (Pomerantz, 1986), which is used to make her account more persuasive. The notion of psychosis being related to trauma is popular in the psychological literature (see Morrison *et al.*, 2003, and Larkin & Morrison, 2006, for a review), and one could wonder whether this discourse is one which is prevalent within 23A's place of work rather than being specific to counselling psychologists, as it is a discourse that has occurred across other participants' talk.

D71

- 1 **Par:** And I think that's often what we do. It's /erm/ it helps for society because
2 obviously when we position (.) the service user, you know, the psychotic patient,
3 however they're described as other, as abnormal, as not okay (.) of course that means
4 that we are because we're not that other. But actually we are. We're all that other.
5 We're all (.) crazy. We're all scared. We're all uncertain. We're all (.hh) all of these
6 things and it's finding a way to come to see that I think that is perhaps healing and I
7 think that's not something, again it's not part of psychological discourse really or we
8 don't talk in terms of compassion and healing and (.hh) those kind of /erm/ terms that
9 again maybe associated with more with kind of a spiritual dimension or religious kind
10 of practice

D71 is using language which argues that in order to make 'normal' people feel better about themselves they 'position (.) the service user' (line 2) as the 'other' and 'abnormal' (line 3). The emphasis on the words 'other' and 'abnormal' seeks to highlight the pathologisation of individuals diagnosed with 'schizophrenia'. However, he follows this by using a list

construction, or a three-part list (Jefferson, 1990), in order to turn this into persuasive account by emphasising that people who are ‘normal’ are indeed the same ‘other’ as the individual who is diagnosed. The list construction he uses is ‘We’re all (.) crazy. We’re all scared. We’re all uncertain’ (line 5).

F1P

- 1 **Par:** Yeah, yeah (1) and you know it’s (hh) what comes across loads and loads and
2 loads with my clients (.) is really low self-esteem, really low self-esteem, and lots and
3 lots of self blame, I mean I’m (.hh) really interested in (.) working with psychosis
4 from a more trauma based understanding (.) because to me it makes the most sense
5 (.h) most of my clients, their voices are the voices of bullies when they were younger
6 (1) of the person that sexually abused them when they were younger, whatever (.hh)
7 but, but holds such significance and when you start to think about it from a more
8 trauma based model

What is noticeable in this extract is F1P’s use of extreme case formulation (Pomerantz, 1986). In this case F1P uses the words ‘loads’ (lines 1-2) and ‘lots’ (lines 2-3) three and two times respectively in order to argue a more psychological account or ‘trauma based understanding’ (line 4) in order to make sense of her clients’ experiences. Sacks (1995) argued that extreme case formulations are deployed by speakers in order to remove the warrant for the pursuit of an account, and to leave the speaker impervious to critique and doubt. Perhaps this can be seen as a device that aims to render the idea of ‘trauma’ more convincing in the interaction. She follows this with a ‘real world’ example about clients hearing the voice of bullies or the person that sexually abused them (lines 5-6), which makes the account even more persuasive.

H17

- 1 **Par:** So when I moved more into this area of work I think the first thing that struck
2 me was that the core conflicts which came up in the work (.) were not different from
3 the ones I'd been working with for many years /erm/ in general mental health

H17 compares working with individuals diagnosed with 'schizophrenia' with individuals encountered in other areas of mental health. By putting an emphasis on 'more' (line 1) it seems that there has been an uncovering of this realisation rather than one that was already present. This suggests that previously there was an understanding that the client group diagnosed with 'schizophrenia' may have been different from the clients he saw in general mental health. He also refers to 'core conflicts' (line 2) which alludes to a psychodynamically informed theoretical base, and that this has been attributed to individuals diagnosed with 'schizophrenia'.

VB2

- 1 **Par:** A lot of the time there's this huge resistance to accepting that people's
2 hallucinations are real for them (.hh) so the focus is on distracting people and getting
3 them to (.) go and do something different, you know, and, and distraction is a really
4 useful technique {laughs}, don't get me wrong, and people need to be educated to use
5 it appropriately, but not to the point where they deny their symptoms (.h) and the
6 system that we have, people deny their symptoms because they think they're going to
7 get out of hospital. They think if they don't have any symptoms they're acceptable.
8 And part of my role with the staff and with individuals in one-to-one work is to say
9 'You're acceptable with your hallucinations. Just because my experience is different

10 from yours doesn't mean yours isn't real for you'

VB2 appears to be using a sandwiched (Riley, 2003) argument in this extract, whereby she presents the 'huge resistance' (line 1) to acknowledging the reality of hallucinations for the client, and then going on to emphasise the focus on 'distracting' (line 2) techniques as if it were something inferior. This is alluded to with the almost dismissive comment of 't:o (.) go and do something different' (line 3) as opposed to engaging with their experiences. The laughter in line 4 also indicates a shift between the previous comment which appears more flippant and the importance of educating people 'to use it appropriately' (lines 4-5). She later resorts again to the importance of accepting 'hallucinations' in lines 9 and 10. This can be seen as an account, counter-argument and account (Riley, 2002).

6.4 Phenomenology and Empiricism

This section follows Williams and Irving's (1996) argument that counselling psychology is torn between the logical empiricist paradigm of academic psychology and the phenomenological paradigm of counselling. It is argued here that this tension can be found in the talk of counselling psychologists and how they position themselves in relation to the diagnosis of 'schizophrenia' through the use of empiricist discourse such as diagnostic manuals, while at the same time attempting to understand the client from their subjective experiences.

6.4.1 The hybrid of counselling psychology as ideological dilemma

Billig and colleagues (1988) identified ideological dilemmas as forms of ideological complexities which occur through common-sense notions of value, community and suitable ways of behaving that are both socially and culturally embedded and that are often conflicting

and contradictory (Towns & Adams, 2009). Edley (2008) argued that there are similarities between ideological dilemmas and interpretative repertoires in that they are both seen as available ways of talking about different objects or events, but that ideological dilemmas carries a further implication in that they suggest that interpretative repertoires are constructed rhetorically: ‘In other words, it implies that the different ways of talking about an object or event do not necessarily arise spontaneously and independently, but develop together as opposing positions in an unfolding, historical, argumentative exchange’ (Edley, 2008: 204).

Within the context of this research, a particular ideological dilemma that was present was related to Williams and Irving (1996) and Spinelli’s (2001) assertion that counselling psychology suffers from a conflicted epistemological framework. As mentioned previously, this conflict is seen as a tension between using a more phenomenological approach to client difficulties, while at the same time engaging in an empiricist discourse. This dilemma was also suggested by Craven and Coyle (2007) using the terms ‘contingent’ and ‘empiricist’ repertoires respectively, which is exemplified by the comment:

‘This could be seen as a response to the dilemmatic position of the counselling psychologist as someone whose professional discourse in counselling psychology foregrounds the therapeutic relationship but who works within a mental health context where the empiricist discourse and the apparatus of diagnosis are generally accepted’ (p.243).

As noted by Burr (2003), ideological workings of discourses are not only located in language, but also in the social practices in which we engage as a society, including the practice of psychology. Edley (2008) argued that the influence of ideology results in

individuals being enticed or encultured into particular, or even partial, ways of understanding the world. Towns and Adams (2009) summarised this dilemma by stating that:

‘Certain dominant ideologies may, for example, influence a person’s social practices in ways that are not comfortable for a person who holds intellectually (that is in their own reasoning and internal debate) an alternative possibility for practice within this dominant ideology. Alternatively, a person may hold an intellectual ideology (which may or may not be informed by academic debates) which is not reflected in their social practices and which is influenced by alternative ideologies or subjugated knowledges. The enacting of these intellectualised alternative possibilities for social practice, however, may be limited by certain mechanisms of power: surveillance or discursive institutional practices, common sense and community ways of being...’ (p.739).

This is exemplified in the following statements:

F1P

- 1 **Int:** OK, so have you, have you worked with an individual or individuals with a
- 2 diagnosis of schizophrenia?
- 3 **Par:** Yup, that’s (.) /erm/ that’s who I predominantly work with. So (.) my role is
- 4 to work with individuals with an F20 diagnosis, so using the ICD-10 (.) classification
- 5 coding system. So it’s anybody with a schizophrenia, schizophrenia spectrum
- 6 diagnosis, it’s who I work with, that’s my remit

23A

- 1 **Int:** OK, so /erm/ my first question is if you've actually worked with an individual
2 or individuals with a diagnosis of schizophrenia?
- 3 **Par:** Yeah.
- 4 **Int:** [Yeah, can you=].
- 5 **Par:** Yeah, I mean my /erm/ my current job is specifically working with people
6 with a diagnosis, if you like, of schizophrenia (.) /erm/ (.) and yeah, experiences of,
7 yeah, psychosis, so /erm/ (.) yeah, that is my total role, if you like
- 8 **Int:** [OK]
- 9 **Par:** I've been doing it for about a year and (.) eight months now /erm/
- 1 **Par:** Yeah, I mean my job role, if you like, was set up specifically by the NICE
2 guidelines and funding is, kind of on the basis of increasing psychological therapy to
3 this client group specifically, and it, I suppose it's aimed at providing CB:T, if you
4 like

Both sections begin with questions by the researcher that invites an account of their experiences, which as Schegloff (1968) noted, can be defined as a conversational opening. As argued by Wetherell (1998), how individuals position themselves in talk is 'highly occasioned and needs to be seen in the surrounding conversation activities' (p.395). Upon being asked if they have worked with an individual or individuals with a diagnosis of 'schizophrenia', both speakers position themselves in relation to institutional and professional levels. So F1P states that she works with individuals with an 'F20 diagnosis' (line 4), or 'schizophrenia', according to the World Health Organisation's ICD classification system and states that it is within her 'remit' (line 6). Similarly, 23A states that her 'total role' (line 7) is to work with individuals diagnosed with 'schizophrenia', and also establishes a sense of

expertise through stating the duration of time she has done so for (line 9). In relation to the ideological dilemmas as set out previously, these two statements argue for the speakers being positioned within a particular way of working or professional framework of understanding and associated talk (Craven & Coyle, 2007). It seems as if F1P's assertion that her role is intimately associated with a revisable political manifesto (Pilgrim, 2007) such as the ICD provides her with an institutional backing befitting her role. 23A's talk about her 'total role' and her length of experience indicates a professional framework required for working with individuals diagnosed with 'schizophrenia'. This can be seen as a form of 'dividing practice' (Foucault, 1982), which in a way objectifies the other and places them within a position which is dependent on the validation of treatment guidelines based on diagnostic classification. Also, this dilemma may also expose a form of opposition (Harper, 1995), which while it may present itself as a conflicted epistemological position, also has the potential to serve as a base for deconstruction by challenging the implicit. By bringing this to opposition to 'awareness', it can be utilised in a manner that allows for the questioning of counselling psychology's epistemological position in relation to the diagnosis of 'schizophrenia'.

6.5 The power of the institution

Boyle (2005) argued that discourse is closely linked with social and institutional practices; it is the aim of this section to examine the discourses related to the counselling psychologists' place of work and training. This is based on the argument that discourse is comprised of both action-orientated discursive devices (Mitchell, 2009) and discursive structures that persist beyond the immediate use of language (Heracleous & Hendry, 2000). Although the debate between the discursive and extra-discursive (e.g. Nightingale & Cromby, 1999) is one which is still ongoing in discourse analysis, this research argues that the

institution plays a role in supporting discourses of certain kinds, while closing other down.

As stated by Hook (2001), to analyse power we need to consider both the ‘discursive effects of the material, and the material effects of the discursive’ (p.538).

6.5.1 The professional organisation as disabling

The context of the counselling psychologists’ place of work will first be examined.

The idea behind this is to explore what constraints are put upon the counselling psychologists from an organisational perspective. For example, how are clients allocated to therapists and who gets to see individuals diagnosed with ‘schizophrenia’ and who does not.

7BT

- 1 **Par:** I think it exists, you know, in the NHS that actually counselling psychologists
2 can’t work in secondary care (.h) /erm/ and actually {laughs} I would >really dispute
3 that< and I think this trust is quite, you know, valuing of (1) actually having a
4 balance, whereas I know other trusts, you know, °are very closed° /erm/ even
5 colleagues I’ve trained with had experiences where people have just gone, °well, no,
6 you’re a counselling psychologist↑, you can’t work in a CMHT [Community Mental
Health Team]’

7BT is taking a position against the idea that the counselling psychologists can not work in secondary care. Her laughter in line 2 appears to shift the direction of her talk from one which marginalises counselling psychologists working in NHS secondary care to one that asserts more power by stating that she ‘really disputes that’ (lines 2-3). Her talk also increases with this which indicates a sense of assertiveness. In this case she aligns herself with her own trust where she is employed and refers to ‘other trusts’ (line 4) as the ones that

close down counselling psychologists. She also appears to engage in a two-sided argument (Abell & Stokoe, 1999), which goes from general NHS secondary care to then praising her own trust by stating that it is 'valuing' (line 3) of having a balance, but then directs her talk towards 'other trusts' (line 4) that closes counselling psychologists down to work in CMHTs.

D71 – Extract 1

1 **Par:** I don't think there's a fixed kind of definite, you know, this is right and this is
2 wrong, it's certainly, you know, it's not black and white in that sense but it often feels
3 that way and it often (.hhh) it often appears, you know, to=that's how it unfolds in
4 practice or in kind of a, you know, in the=certainly in kind of an institutional (.)
5 setting or organisational setting like the NHS. It's a lot of shorthand, you know, you
6 might have somebody (1) banging, knocking on the (.h) on the door of the, you know,
7 nursing /erm/ station in a acute psychiatric ward and I think when somebody's (.h)
8 received that label or they're spoken of as being a schizophrenic or even if people are
9 very great saying a person who, you know, is experiencing or suffering with
10 schizophrenia, it's very easy to dismiss that person and not to see them as part of
11 yourself, it becomes very other, it becomes very (.h) and it's, yeah, it's those kind of
12 implications in effect that feels really dehumanising and, yeah, subject to abuse
13 basically

D71 – Extract 2

1 **Par:** But in somewhere like the NHS, you know, that's maybe not the kind of speak
2 or what people are concerned with because there's the (.h) on the floor reality and the,
3 you know, I'm sure you've heard the term fire fighting, that's often how it feels in
4 crisis management (.hh) so to try and put the handbrake on and to have these

5 conversations is hugely difficult. You know you're talking about a, a huge cultural
6 shift, a shift in world views and that, you know, paradigm shift and it's just, that
7 doesn't happen overnight or easily

D71 is referring to how both he as a counselling psychologist and the client are positioned within the institution. He appears to say that if client has received a diagnosis of 'schizophrenia' they are easily dismissed. He refers to the notion of the separation of the client from other workers within the mental health team, and how this opens the experience up to dehumanisation and the potential for abuse.

In the second extract he talks more about how the 'reality' (line 2) on the floor causes the kind of talk that opens up the 'schizophrenia' experience to close down. He refers to this as 'fire fighting' (line 3) in 'crisis management' (line 4), where the intense levels of work results in a diminishing of the talk needed for opening up other ways of looking at 'schizophrenia'. These appear be extreme case formulations (Pomerantz, 1986) that aim to make his account more persuasive by appealing to what seems to be the often distressing nature of working in psychiatric units. He refers to a 'huge cultural shift' (line 5) and a 'paradigm shift' (line 6) as being needed in order to alter this way of looking at 'schizophrenia'.

F1P

1 **Par:** You've got your CBT, psychodynamic, your integrative, your family
2 therapy, they run groups (.) /erm/ and they'll deal with PTSD and complex PTSD,
3 anxiety, OCD:D, panic, /erm/ complex depression and chronic depression (1) and they
4 need people to be fairly severe, what I've got down here, it's moderate to severe
5 complex mental health problems is what they take (.hh) /erm/ but their exclusion

6 criteria is anyone with a history of psychosis (1) {laughs} and that I think, you know,
7 speaks volumes, which is why my role's come about (.hh) /erm/ but, yeah, (hh)
8 there's still that idea of well do this nice little package of therapy, we offer all these
9 nice packages of therapy but not if you're psychotic, you know, we won't work with
10 you

FIP refers to how other psychiatric 'diagnoses' are seen as being amenable to psychological interventions while 'psychosis' is not. She does this by using a list construction (Jefferson, 1990), which aims to make her account more persuasive. The patterns she follows appears to be a five-part list for the therapeutic approaches offered (lines 1-2) and a seven-part list for the client presentations or diagnoses (lines 2-3) that are actually offered the afore mentioned therapies. She also refers to her 'role' as coming about because of this and then offers a bottom line argument (e.g. Edwards *et al.*, 1995) which ends with 'we offer all these nice packages of therapy but not if you're psychotic, you know, we won't work with you' (lines 9-10).

IW8

1 **Par:** I feel a bit /erm/ alone at times {laughs} /erm/ probably caught me on quite a
2 bad week really {laughs} /erm/ but feel like it is a constant struggle /erm/ to change
3 stigma and perception /erm/ (1) guiding the way we work with people /erm/ and not
4 so much for me psychiatry interestingly, but nurses and, well you got nurses, social
5 workers /erm/ in the team but probably more nurse, nurse, nurse profession really that
6 struggle to formulate and to understand the importance of relationships sometimes
7 and are quite scared of some relationships with some clients, becoming too
8 dependent or being quite rejecting or /erm/ you know, really struggle with that and

9 revert back to kind of medical models and ways of working at times when they are
10 struggling with relationships I think, so I think as a counselling psychologist, I mean,
11 I am the only psychologist in [] working in=at this level with patients (1) and you
12 have to >network quite well really to keep your links outside with your profession
13 because< you can feel like going into battle sometimes, but there are individuals that
14 you have been helping to develop and helping them to think differently, but /erm/ it
15 can be a struggle at times to do that /erm/ perceptions

Here IW8 positions herself as alone in a sea of individuals who do not understand the nature of her work or what she finds important, namely ‘relationships (line 5). However, within this she also takes on the responsibility of trying to ‘change stigma and perception /erm/ (1) guiding the way we work with people’ (lines 2-3). She is then quick to assure that it is not ‘psychiatry interestingly’ (line 4), which indeed makes the assumption that it is psychiatry whose stigma and perception of clients is the one that needs change. She also says that these individuals are ‘scared’ (line 6) of these types of relationships and that they use the medical model as a form of protection against clients. What emerges in this talk is a sense of isolation from her peers, and that in order to receive the support she needs she has to go ‘outside’ (line 11) in order to maintain links with other people from her ‘profession’ (line 11). She also states that her location of work (removed to maintain anonymity) (line 10) seems to state that she is the only counselling psychologist working in that locality in her capacity.

VB2

1 **Par:** And it’s not difficult for a counselling psychologist to work with people with a
2 diagnosis (.hhh) having said that {laughs}, a lot of the struggle that I have is with the
3 psychiatric diagnosis because (.) there is /erm/ there is an element of the psychiatric

- 4 (.) mindset that says that counselling and therapeutic work (.) is (.) not useful to
5 people with schizophrenia

Here VB2 is referring to the ‘mindset’ (line 2) that is prevalent in the organisation, and which is used to marginalise her as a counselling psychologists offer ‘counselling’ (line 2) and ‘therapeutic work’ (line 3).

6.5.2 *The professional organisation as enabling*

Even though the talk presented above refers to the institution as a disabling feature in counselling psychologists’ work with individuals diagnosed with ‘schizophrenia’, some participants presented the institution as a supportive environment for their work. However, this also raises questions regarding counselling psychologists and their positions within these organisations, and what implications this may have for their professional identity.

23A

- 1 **Par:** But I think (1) when services support it, because I guess the trust I work in
2 /erm/ (2) you know, that they ask for trainees to come and work in the, kind of, more
3 /erm/ complex psychology service, I guess (.h), you know, they’re actually saying
4 yeah, you can work with this client group and they’re, kind of, yeah, we want
5 trainees >so that’s kind of saying, it’s sort of opening it up a bit< /erm/ and then
6 maybe from that, you kind of then get to experience more complex difficulties, so it
7 does help, I think, when services out there kind of (.), you know, advertise or open
8 things up a bit

Here 23A is referring to the organisation as paving the way for counselling psychologists to be exposed to work with individuals diagnosed with 'schizophrenia'. However, there is a question whether the organisation is more open to free labour as opposed to opening the eyes of trainee counselling psychologists.

F1P

- 1 **Par:** I discovered that I was in a very different position to a lot of my colleague:s
2 who °wouldn't touch schizophrenia with a barge pole° {laughs}, you know, and so
3 even on my placements and everything else I was still working with psychosis,
4 because I'd worked with it (1) before even contemplating psychology as a career (.hh)
5 I don't know, I, I, I, I, I guess it just meant that I had this understanding of this is what
6 we do in the mental health {laughs} services [**Int:** Yeah, yeah]. This is how we work
7 with individuals

F1P is positioning herself in opposition to colleagues who would not consider working with individuals diagnosed with 'schizophrenia', or who 'wouldn't touch schizophrenia with a barge pole' (lines 1-2). This is an extreme case formulation (Pomerantz, 1986) which serves to emphasise the reluctance of her colleagues to work with this client group. She appears to credit her experience in working within organisations to this, which in turn leads to a greater understanding and awareness of working with this client group. However, her assertion that 'This is how we work with individuals' (lines 5-6) also sets up a form of a dilemma, as before she argued that there is a need for greater subjective understanding of the 'schizophrenic' experience, by using this statement she appears to fall into line with the organisation discourse on how to work with individuals diagnosed with 'schizophrenia'. She appears to acknowledge this contradiction by presenting some hesitation and ambivalence through the

repeated use of the word 'I' (line 5). Nofsinger (1991) referred to this as a repair and occurs at a point where she moves into talk that aligns herself with the 'mental health {laughs} services' (line 6). Her laughter in line 6 also may serve as an acknowledgement of what she has just said or not to take her statement too seriously.

6.5.3 *Training as disabling*

Many of the speakers saw the counselling psychology training programme as a hindrance to work with individuals diagnosed with 'schizophrenia', and this will be explored next. As outlined by Parker (2002), universities themselves can through certain institutional practices function as 'disabling' influences on the trainees.

7BT

- 1 **Par:** So your experience as a trainee of working with this client group very much
2 depended upon where you managed to get a placement [**Int:** Yeah], and for some
3 people, that always was in voluntary sectors [**Int:** Yeah] /erm/ and the teaching – I'm
4 trying to think what teaching we had, and I can't imagine it was even /erm/ more than
5 a day [**Int:** Mmm], you know – so I think there was=there is this assumption actually
6 that well, you know, 'that's dealt with (2) by clinical psychology', 'it's not
7 necessarily something you need to °worry about' you know, 'you stick to your
8 bereavements and your depression'° >and actually<, no, I've, because from day one,
9 I was in a CMHT so yeah, there was an element of having to pick up clients that were
10 relevant to my level of studying (.h) /erm/ but (2) it didn't feel the university fostered
11 that confidence in working with this specific client group, as much as it perhaps drew
12 out the anxiety-based difficulties or /erm/ you know (2)=even with substance issues
13 and things like that you know, °it just wasn't something°=>in fact, that was probably

14 looked at< °more than working with, kind of, schizophrenia and psychosis°

7BT argues that because counselling psychologists tend to acquire placements in voluntary settings rather than NHS secondary care settings they have less exposure to individuals diagnosed with ‘schizophrenia’. She places much emphasis on the word ‘that’ (line 2) which works to persuade that some people did not have the desire to work in settings other than voluntary ones. She also appears to relate to her lack of teaching around the topic on assumptions made by the university that working with individuals diagnosed with ‘schizophrenia’ is done by clinical psychologists rather than counselling psychologists, and that it is nothing we need to worry about. She makes an extreme case formulation (Pomerantz, 1986) by stating, in what seems to be a derogatory way as her talk lowers, ‘you stick to your bereavements and depression’ (lines 7-8) before her talk increases as she takes a stand and exclaims ‘>and actually<, no’ (line 8). She states that the assumptions made are incorrect because ‘from day one, I was in a CMHT’ (lines 8-9).

D71

1 **Par:** But it’s, you know, I don’t want to sully that or make that sound as though
2 that’s a technique because it isn’t, that’s just something that emerges and that is real in
3 the room. Maybe there is a way of, of formalising and putting it in textbooks, that’s
4 fine, yeah, I guess I just think when good things happen in a room it’s not about skills
5 and (.hh) maybe you keep an eye on that in the periphery, maybe that is part of kind
6 of it=of course it comes with you because you’ve had that training or you’ve read that
7 book or whatever (.hh) but if you’re focused on that, if you’re going in with your (.),
8 you know, this person’s traumatised or this person’s got, you know, you’ve read the
9 latest paper or, you know, you’re hooked up on some theory of, kind of, repression or

10 trauma or whatever, in whatever capacity, whatever {laughs} that might be, and
11 you're focusing on that, you're going to miss it by a mile really

Here D71 is making references to the therapeutic relationship and how it 'emerges' (line 1) as something 'real in the room' (lines 2-3). He alludes to the relationship as a phenomenon that is beyond technologising as he seems to be dismissive of being able to define the relationship in a textbook by saying 'that's fine, yeah' (lines 3-4). He then refers to the 'good' things that happen in the room, implying that the bad, or perhaps not as real, is more about 'skills' (line 4) and that by acquiring theory through training you miss what is happening with the client.

F1P – Extract 1

1 **Par:** I mean I felt quite angr::y after my training, when my training finished I felt
2 really angry at how little the course focused on psychosis (.h) how little we were
3 equipped to work with psychosis or deal with psychosis

F1P – Extract 2

1 **Par:** >And it was all about risk and managing risk because this person was high
2 risk, the case that had to do with this person was a high risk of (.h) creating a bomb to
3 blow up the local opticians °and I was so angry because° to me it fed into all the
4 stereotypes (.hh) and the myths and the negative (.h) stereotyping of somebody who's
5 unwell and experiencing psychotic {laughs} symptoms (1) it didn't in any way shape
6 or form equip us to deal with it, it was how do you recognise it, how do you manage
7 that risk, and refer on

F1P – Extract 3

- 1 **Par:** Yeah, yeah, completely, you know the message was loud and clear (1) we
- 2 don't touch this, you know, you send that off somewhere else (.hhh) /erm/

Again F1P appears to be using extreme case formulations (Pomerantz, 1986) in all three extracts surrounding her training as a counselling psychologist. However, there are some differences between them which will be outlined. The first two extracts relate to F1P's anger surrounding the lack of training surrounding the diagnosis of 'schizophrenia' in line 1 of extract 1 and the negative stereotyping present when the issues was discussed in line 3 of extract 2. The social constructions of emotions (Parkinson, 1995; Walton *et al.*, 2004), such as anger are argued to have rhetorical functions (Edwards, 1999). In extract 1 the word 'angry' (line 1) is drawn out and is presented as a past tense in that when F1P had finished her training her anger became apparent. In extract 2 the word 'angry' (line 3) is surrounded by more quiet talk, and is presented in the present tense (as in she was still on the course when she felt angry). The other extreme case formulation concerns the message that was received from the training body with regards to working with individuals diagnosed with 'schizophrenia', which was one that was 'loud and clear' (Extract 3, line 1).

6.5.4 *Training as enabling*

In contradiction to the repertoire above, some participants saw the training provided as something that enabled them to work better with individuals diagnosed with 'schizophrenia'.

7BT

- 1 **Par:** I think (2) as a counselling psychologist, certainly my=at the uni went to, were
- 2 very heavily thinking about (3) being with the client in your first few sessions,

3 thinking about establishing a therapeutic relationship /erm/ and actually having any
4 intervention as being secondary to that [**Int:** Mmm], so I think in ↑that sense, >it's
5 probably come across in what I've been saying↑, but I think in that sense, that's kind
6 of shaped my ability to actually be a bit more flexible< with this client group and not
7 feel more pressured into having to produce results

7BT refers to the more 'relational' nature of her training which put a more technical
'intervention as being secondary' (line 4). She appeals to the interviewer to acknowledge this
in her previous talk by stating that '>it's probably come across in what I've been saying'
(lines 4-5). This appears to be a form of disclaimer (Hewitt & Stokes, 1975). 7BT appears to
want to ascertain that she has been, and will be, understood correctly. She also seems to want
to leave the impression that she is 'flexible' (line 6) and that she does not feel 'pressured into
having to produce results' (line 7).

23A

1 **Int:** >And do you feel as though your role as a counselling psychologist has
2 actually prepared you for that kind of flexibility and that kind of role?<
3 **Par:** Yea:h, I think so, because I think=I suppose through our training, we have=I
4 guess we work in so many different placements, we have to be able to juggle things,
5 we have to (.h) be creative, I think, sometimes and I think definitely /erm/ I think it's
6 allowed me to do that and (1) maybe because there's such a focus on the relationship,
7 I guess, in our training and building that with someone, you know, you don't
8 necessarily feel that you have to (2) kind of be so=yeah, technique-focused all the
9 time=well, I don't know if that's me personally, or if it is because of the training, you
10 know, I think (.) maybe it's a bit of both /erm/ I think, yeah, I think our role (1) maybe

11 surprisingly, does fit really well

23A is referring to how her training has allowed her to be 'creative' (line 5), which has in turned helped her adapt to the different roles required of her. She also focuses on the technique based aspect of it, or rather lack of technique, by saying that she does not have to worry about being so 'technique-focused all the time' (lines 8-9). Her emphasis on 'surprisingly' (line 11) almost seems to be a surprise in itself.

IW8

1 **Par:** But what (.) I'm finding is my roots to my training and the /erm/, the /erm/ (3)
2 concentration on the therapeutic relationship and all the fundamentals that we learnt
3 on the course help us more than you imagine really I think /erm/ (3) and I don't think
4 I did feel very prepared, but I don't think they can prepare you for everything that you
5 are going to face (.) when you finish and I think that although we were, kind of, taught
6 diagnosis on the course (2) /erm/ (3) that that was not, you know, we did assessment,
7 formulation, you know, what would the diagnosis fall under, you know, and then
8 treatment we kind of felt in the right way round really because (.h) there is something
9 important about diagnosis I think as well in terms of us all speaking the same
10 language in a way, it helps us to communicate something about, you know, (1) types
11 of people and their problems I guess which can be, can be useful, but I say again, the
12 training kind of, I think it was just about, it still is really, just about building up your
13 confidence with working and remembering what's important I think and not getting
14 drawn into diagnosis's, scare stories /erm/ and just seeing people and seeing how they
15 relate to you working, if you can work with them and that's what's really important

IW8 begins by referring to the 'roots of her training' (line 1) with a particular focus on the therapeutic relationship, and how this has helped more 'than you imagine' (line 3). However, there is a concessionary element (Antaki & Wetherell, 1999) to this argument that follows, which begins with saying something vulnerable to challenge, or a proposition, such as in line 3 where she states that the fundamentals learnt on the course are more helpful than you think. This is then followed by a concession in lines 3 and 4, where she states that she did not feel particularly prepared. Finally, this is in turn followed by a reprise in lines 4 and 5 that reassert that you can not be prepared for everything you will face. Antaki and Wetherell argued that show concessions are used to fortify the speaker's position against misunderstanding or attack, and it seems as in IW8's case, there is a protective element whereby she supports her training, but also states that it sometimes does not feel enough. This is followed by a two-sided argument (Abell & Sokoe, 1999) about the nature of diagnosis on the course, where she argues that learning about diagnosis is seen as a form of pragmatism in order to communicate with clients, while at the same time not being drawn into the 'scare stories' (line 14).

7. Discussion

7.1 Introduction

By attempting to conduct a critical discursive account of counselling psychologists' talk about the diagnosis of 'schizophrenia' this research was interested in examining some of the axes of difference (Parker, 1997) present in discourse analysis as an approach, which in turn reflected the same differences present in the talk of the participants. This is to say that by using the diagnosis of 'schizophrenia' as a talking point, the analysis intended to explore the micro and macro (Parker, 1997) and the discursive and non-discursive (Sims-Schouten *et al.*, 2007) which a critical discursive account attempts to capture. How much was managed between the two will be discussed below, and it seems fair to say that there was a particular bias towards the macro rather than the micro as the epistemological basis for this research was critical realism (Nightingale & Cromby, 1999). However, what has been attempted is to try and provide a glimpse of how a certain sample of counselling psychologists have positioned themselves in relation to the diagnosis of 'schizophrenia', as an experience and in relation to the material and institutional constraints which act upon discourse (Parker, 1992; Sims-Schouten *et al.*, 2007). For as proposed by McNamee and Gergen (1992), our understandings of 'mental illnesses' such as 'schizophrenia' are ideologically shaped and institutionally reinforced constructions rather than 'truths'. Other questions that will be discussed here include causality in discursive and critical realist work as it relates to the research question, and reflexivity and the influence of the researcher on the development and process of the research itself, and how this is an inescapable part of the research endeavour.

7.2 The Notion of 'Implications' and 'Applicability' in Research

Before beginning, it is important to reflect on the idea of the implications and the applicability of the research. Willig (1998) argued that discourse analysis is an attractive tool for critical psychologists because it allows us to challenge and question what is taken for granted in psychology. However, she also argues that discourse analysts have been reluctant to move beyond the practice of deconstruction and make recommendations for improved social, political and/or psychological practice. She draws this argument back to the relation between epistemology and political actions, whereby relativism is accused of having a paralysing effect, thereby resulting in an inability to commit to a definitive political position. The reasons for such reluctance have been identified as a '(i) fear of becoming guilty of reification, together with a strong commitment to contextualised analysis, as well as (ii) an acute awareness of the possibility of political abuse of research findings' (Willig, 1998: 95). In the context of this research, the idea that what has been produced can somehow be objectified, abstracted and then 'applied' in a different context is somewhat problematic. Widdicombe (1995) advised that researchers should not commit themselves to particular recommendations based on their research, and in order to avoid imposing categories upon others one should seek to contextualise the analysis as opposed to generalizing. In the case of this research it was a matter of 'adding' to the discourse on 'schizophrenia' in counselling psychology, rather than engaging in the more technical discourse of 'applicability'. For example, with regards to dissemination of research, as the reproduction of texts within academic circles only serves to influence a minority or those already converted, Pilgrim and Treacher (1992) found that practice could be influenced more through word of mouth and training workshops than the use of publications.

So in light of these arguments what will be offered in this section may be seen more as notions of usefulness (Misra, 1993), and what is meant by this is whether a particular idea

or intervention leads to a richer understanding and to more just and socially responsible outcomes (Harper, 1999), rather than using the rhetorical power of applicability. In order to do this the next section will focus on the ‘notions of usefulness’ of the research. One could of course argue that by even suggesting this the author is guilty of ontological gerrymandering (Woolgar and Pawluch, 1988), which describes the ‘analytic practice of explaining certain phenomena as socially constructed, while positioning other phenomena as being beyond the boundaries of constructionist explanation’ (Howard & Tuffin, 2002: 85). However, the analysis presented in this research can not claim to be more ‘true’ than any other, but rather notions which have emerged from the co-constructive nature of the research process between the researcher and the participant (Mauthner & Doucet, 2003). As argued by Taylor and Loewenthal (2001): ‘We can never come to the end of the meaning of a text, because there will always be another perspective on it’ (p.71).

7.3 Usefulness for Counselling Psychology

This section will aim to summarise the discourses identified by the research and allow the reader to take from them what they find ‘useful’ for their own theoretical thinking and practice. As mentioned previously, these accounts are not intended to be a demonstration of ‘truth’, but only what was found within the context of the researcher’s and participant’s local interaction.

7.3.1 The Therapeutic Relationship

This repertoire was included on the basis of how it was used in the counselling psychologists’ talk. What was particular about this repertoire was how it was employed in order to differentiate the counselling psychologists’ practice from the practice of other ‘mental health professionals’. As argued by Pugh and Coyle (2000), counselling psychology

has constructed itself as achieving in areas where clinical psychology has failed, and this appears to have been a position that was in some ways constructed by the participants as well. There was a particular emphasis on the therapeutic relationship versus technique, and that it was more helpful to stay with the individual rather than jump in with, for example, CBT interventions. This is in line with what Magnavita (2000) referred to as a relational approach, whereby the 'therapeutic process is held to rely most heavily on the quality and mutual experience of the client-therapist relationship rather than on any particular set of techniques' (p.999). There was also an example where the therapeutic relationship was deemed to provide something that had not been provided in standard mental health care and that instead of closing down or silencing the individual diagnosed with 'schizophrenia', the relationship instead fostered something 'real'. What was common in the talk of the participants was the idea that because of the dominance of the medical model in standard mental health care and the conceptualisation of 'schizophrenia' as a biological disorder, the importance of the therapeutic relationship has been denied to individuals diagnosed with 'schizophrenia' (Repper, 2002). This is understandable when one considers that the use of the therapeutic relationship to work with individuals diagnosed with 'schizophrenia' has been criticised as being indefinable and irrelevant to mental health practice (Coleman & Jenkins, 1998), and that the absence of randomised control trials and controlled evidence in the role of the therapeutic relationship has been seen as proof of its lack of efficacy (Lambert & Gournay, 1999). The medicalisation of distress and the use of diagnostic labels have placed the source of distress firmly within the individual; this may disregard the value of understanding the social context and interpersonal relations as sources of dysfunction (Hare-Mustin & Marecek, 1997).

However, what was interesting was that the therapeutic relationship itself is being used as a political issue in order to affirm the identity of counselling psychologists working with individuals diagnosed with ‘schizophrenia’. One could ask whether this is a case of counselling psychologists actually providing a contrarian position within the institution in relation to individuals diagnosed with ‘schizophrenia’, or whether recent developments in mental health care has ‘allowed’ for this particular position to be taken. For example, have documents by ‘prominent’ psychologists (in particular clinical psychologists such as Richard Bentall, Mary Boyle and Paul Chadwick that are often vocal about ‘schizophrenia’) such as *Recent Advances in Understanding Mental Illness and Psychotic Experiences* (BPS-DCP, 2000), that advocate a more relational approach to working with individuals diagnosed with ‘schizophrenia’ been used to legitimise counselling psychologists’ discourse surrounding their work with this client group in NHS settings? There is no escaping that recent literature on individuals diagnosed with ‘schizophrenia’ has often expressed the importance of the therapeutic relationship (Coursey *et al.*, 1995; Fenton, 2000; Johansson & Eklund, 2003; Guimón, 2004; Hewitt & Coffey, 2005; Lysaker *et al.*, 2007) and how this sometimes seems to be lacking from their care, and it seems like counselling psychologists who work in settings with this client group appear to take that into account and attempt to use a ‘relational’ approach in their therapy.

7.3.2 Relating to the Individual’s Experience

This was a common repertoire across all the speakers, which might be expected considering counselling psychology’s focus on the phenomenological (e.g. Woolfe, 1990; Lane & Corrie, 2006). However, it was how this was presented between the speakers that presented a greater point of interest, and by exploring the functions (e.g. Coyle, 2007) of their talk we can explore some of the variation that emerged. As presented in previous counselling

psychology literature there is a great emphasis on questions concerned more with ‘should we or shouldn’t we?’ in relation to presentations considered more ‘severe’ such as the diagnosis of ‘schizophrenia’. The extracts that were presented under these repertoires seemed very much in favour of ‘we should’. The practice of relating to the individual’s experience is a common rhetoric in counselling psychology literature, however, in the case of ‘schizophrenia’ it is less so. This may be as a result of existing, and often psychiatric, discourse such as Jaspers’ (1963) arguing that the ‘schizophrenic’ experience is one which ‘un-understandable’ and should not be engaged with, and that the talk of the individual diagnosed with ‘schizophrenia’ should be seen as a by-product of the ‘illness’ and dismissed as ‘word salad’ (e.g. Torrey, 2006; Titone, 2010). However, this view had been challenged by individuals such as Laing (1990b) who argued that even the ‘schizophrenic’s’ experience was a valid lived one and should be listened to. As argued by Geekie (2004): ‘I argue that those voices, both in the professional literature and in clinical settings, have been marginalised and this has been to the detriment of clients’ interests, clinical practice and research efforts directed at investigation the nature of the experience’ (p.149). In the case of the counselling psychologists interviewed, there appeared to be an attempt to cross this bridge, however, there still seemed to be some guarded negotiating in their talk. For example, the idea of ‘schizophrenia’ was reified in the counselling psychologists’ talk, and as argued by Boyle, (2005) this indicates that ‘schizophrenia’ is seen as something out there which can be discovered; however, in the case of the counselling psychologists’ talk, this reification was ascribed more ‘meaning’ or something to understand, and that experiences can somehow be interpreted. This was also argued to be a useful method in establishing a therapeutic relationship. Geekie (2004), referring to Foucault (1980), argued that this is a form of ‘subjugated knowledge’, which is the knowledge that individuals diagnosed with ‘schizophrenia’ have about their own experiences, but which is usually marginalised in

research literature and the therapeutic encounter. In relation to the counselling psychologists, this does not seem to be the case; instead they appear to be presenting a form of counter-discourse, which aims to counter the domination of prevailing authoritative discourses (Moussa & Scapp, 1996) with an alternative construction (Willig, 2008).

However, it is also important to note that even though they may approach the individual's experience in this manner, there is still an element of 'otherness' (e.g. Cooper, 2009) between the counselling psychologist and the individual diagnosed with 'schizophrenia', but this may be argued for all 'clients' and not just the 'clients' diagnosed with 'schizophrenia'. There has been a greater call for trying to relate to the individual's experience in the literature pertaining to 'schizophrenia' (e.g. Jenkins & Barrett, 2003; May, 2004; Knight, 2005; Geekie & Read, 2009) and perhaps counselling psychologists may find themselves in a position to conduct further research in the area. However, there are still some fundamental difficulties with this, particularly if counselling psychologists continue to adhere to the scientist-practitioner model, when the model is immersed in discourse such as:

'As a practitioner, it is valuable to be able to develop the ability to take a step back from the emotive-relationship-based aspects of applied psychology and explore client responses, behaviors, and sessions from a scientific viewpoint. Observing clients, making inferences, formulating a hypothesis, and testing the hypothesis are all important to applying the scientist component to being a practitioner' (Petersen, 2007: 763).

This type of rhetoric may make it difficult for counselling psychologists to engage with the experiences of their clients, while still trying to balance the individualised view of

the scientist-practitioner model; and indeed, some argued that the scientist-practitioner model has seen counselling psychology moving closer to clinical psychology and an emphasis on the medical model (Vespia & Sauer, 2006). Also, as argued by Eilan (2000), there is also a danger that by trying to understand the client in a phenomenological way, and acknowledging that the experience has meaning for the client, the therapist may draw on other discourses (such as psychodynamic) in order to make sense of the experience. Perhaps this an inevitable part of the ‘psy-complex’, which as presented in the interviews lives out in the talk and experience (Parker, 1997) of the counselling psychologists and an unavoidable part of being a ‘professionalised’ psychologist working in contemporary mental health services.

7.3.3 Normalizing the Experience

Milton and colleagues (2010) argued that counselling psychology values the subjective experiences of the client over and above notions of ‘pathology’ that classifies and categorises the individual. This position may seem similar to relating to the experience; however, what was different about the use of this talk was that the counselling psychologists often used other presentations such as OCD or PTSD in order to normalise the individual’s experience. What was evident as well was how the counselling psychologists used themselves in order to normalise the experience through using repertoires such as ‘we are all crazy’. In contrast to attempting to relate to the experience, which seemed at times to create a barrier between the clients and the practitioners, this repertoire was very much about closing that distance. This may be seen as an attempt to diminish the effects of what Morrison (1992) and later Sampson (1993) referred to as the ‘serviceable other’. The serviceable other was described by Morrison in relation to how White authors construct African Americans, and specifically how White authors construct African Americans in a certain way in order to provide the identity they wish for themselves. Sampson explored the same concept but from

the positioning of women, gay men and individuals from 'third world' countries, whom he argued had become serviceable to the fears and desires of the dominant male, heterosexual white groups. Even if counselling psychologists attempt to normalise the experiences of individuals diagnosed with schizophrenia, there is still an issue, as argued by Parker and colleagues (1995), that accepting the idea of the 'pathological' as 'normal' can be unhelpful as there is still a need to challenge the practices that cause the divide to begin with (see, for example, Garret and colleagues (2006) where 'normalisation' is achieved through the application of 'cognitive' rhetoric). One could ask whether trying to understand one psychiatric 'diagnosis' is more helpful through its comparison to other, equally controversial, diagnoses such as PTSD? In a way this again relates to the idea of the 'ununderstandable' notion of the 'schizophrenic' experience, which appears to contradict what individuals spoke about earlier when relating to the experience. Mullen (2007) outlined a phenomenological approach to 'psychopathology', which attempted to incorporate subjective experiences as argued by Husserl and Jaspers. However, he concluded that there was even a danger in the phenomenological approach:

'It might be objected that when this account is stripped of good intentions and caveats, all that remains is exactly the approaches to clinical examination and psychiatric nosology that this phenomenological method was supposed to counter and improve. Is it differentiated only by the dubious claim to be constantly and self-consciously provisional and tentative? Or worse still, is it only distinguished by the politically correct embracing of refutability? The answer to such objections lies perhaps in the modesty of the phenomenological method which strives to clarify and explore not to create authoritative systems' (p.118).

This indicates that even though counselling psychologists seem eager to embrace the discourse surrounding the values of their profession when working with individuals diagnosed with ‘schizophrenia’, while at the same time incorporating discourses surrounding, for example the service user (Campbell, 1996, 2002) and recovery movements (Deegan, 1988, 1996) (which both advocate the normalisation of ‘psychotic’ experiences, but more as a personal process), as ‘mental health professionals’ there may be a danger in doing more harm than good. This relates to Andreasen’s (2007) warning that what is understood as being ‘phenomenological’ can at times lead to the practice of classifying experiences rather than attempting to understand them.

However, in line with a more critical approach in psychology, counselling psychologists do attempt to focus on the social origins of their clients’ distress, rather than overtly medicalise them and ‘cure’ (Nightingale & Neilands, 1997). By attempting to normalise their clients’ experiences one could also argue that there is an egalitarian (Woolfe, 1996; Strawbridge, 2006) element to the practice. It is worth considering, however, as argued by Hart (2003), that there may be a difficulty in balancing the notion of expertise and equality in the relationship, particularly when, as mentioned above, linguistic aspects of ‘pathology’ are reinforced through the use of other diagnostic categories in order to understand individuals diagnosed with ‘schizophrenia’. This may be something for counselling psychologists working in this area to consider, and how they position themselves as the ‘sane’ speaker who have control over who they place ‘madness’ on (Hook & Parker, 2002).

7.3.4 The Hybrid of Counselling Psychology

This repertoire relates to the presence of a tension in counselling psychology as outlined by Williams and Irving (1996) and Spinelli (2001), whereby there is an

epistemological contradiction inherent to the theory of counselling psychology. This places counselling psychology between a phenomenological appreciation of client experiences, while also adhering to the logical-empiricist discourse of modernist psychological theory (e.g. the scientist-practitioner model). This talk was evident in participants' references to empiricist manuals such as the DSM and ICD, and also through the use of diagnostic categories. However, it must also be understood that the participants are situated within an organisation such as the NHS, where psychiatric classification is the dominant language for discussing and thinking about an individual's difficulties (Golsworthy, 2004). This type of talk varied greatly between participants, with certain individuals adhering more to the more 'medicalised' discourse whilst others were more aware of its implications. The danger of this type of talk has been outlined by Foucault (1972), who stated that: 'psychiatric discourse finds a way of limiting its domain, of defining what it is talking about, of giving it the status of an object – and therefore making it manifest, nameable, and describable' (p.46). However, this may be related to the identity, or rather lack of identity, of counselling psychology as a profession as it seems that counselling psychology is fighting an internal struggle between its place in the NHS hierarchy and the supposed philosophical, albeit conflicted, values it holds in such high regard. Ironically, Hansen (2005a) argued that counselling has started moving away from valuing 'inner experience' of clients because of the profession's increasing medicalisation as well as its emphasis on social constructionism, and states that in order to reclaim this 'unique' philosophy of counselling it needs to affirm its identity. Owen (1992) suggested that there are three elements that contribute to the establishment of an identity: how members of the profession perceive themselves; how others perceive them; and what they actually do (Lewis & Bor, 1998). It seems as if there are still some unanswered questions regarding this in counselling psychology. This issue may also be related to what Laing (1990) named the ontological insecurity in individuals diagnosed with 'schizophrenia',

however, in the case of counselling psychologists perhaps there is an epistemological insecurity in how to approach individuals diagnosed with 'schizophrenia'. The ambivalence this raises is summed up by Fretz (1980) when he says that: 'Counseling psychology, it seems, is in the eye of the beholder' (p. 9).

As stated by Rizq (2006), counselling psychology's pluralism may be a great advantage in that it does not consider any theoretical, epistemological or methodological approach to be superior. However, within this pluralism comes an inherent danger that upholding these often contradictory epistemologies results in confusion and a sense of theoretical relativism (Kenwood, 1999), which may undermine any political position that challenges the use of psychiatric diagnoses such as 'schizophrenia'. As presented by Lyddon (1998), even though social constructionism has offered many interesting and important ideas for counselling psychology, rarely is there an emphasis on self-critique, suggesting that the philosophical value base of counselling psychology has itself become a 'holy cow' (p.219). Cosgrove (2005) argued that we need to be aware of binaries and making either/or choices, and must instead encourage healthy debates about psychiatric diagnoses and their uses and abuses. This type of thinking should, of course, be encouraged, but there is an acknowledgement that this is more and more difficult to do in practice (e.g. Hansen, 2005b). For example, Chwalisz (2003) alarmingly proclaimed that counselling psychologists need to embrace the 'health care system' (i.e. the medical model) or professionally we will be left behind by 'system that is moving ahead without us' (p.515). Also that by not doing this will result in 'restricting roles and decreasing opportunities' (p.498), while embracing the medical model will lead to the 'growth' of counselling psychology and an 'expansion of opportunities' (p.499). She summarises by saying that: 'It is to our advantage to speak the same language and be accepted as contributing members of the health care system', and only

then will we 'be able to effect changes in the system consistent with our values-from the inside' (p. 515). Chwalisz seems to be approaching this from a professional and material viewpoint, which, in danger of being accused of 'ontological gerrymandering' (Woolgar and Pawluch, 1985), is an important element to consider in the theory and practice of counselling psychology.

7.3.5 The Professional Organisation as Disabling and Enabling

Here we attempt to turn to the 'extra-discursive' (Sims-Schouten *et al.*, 2007) to explore the implications of this for counselling psychologists. The debate between the discursive and the extra-discursive is, as mentioned earlier, one which is still being debated between discourse analysts. However, for the sake of this research it seemed appropriate to attempt an understanding of how the organisational or institutional setting may have an effect on the counselling psychologists working within them. The repertoires included a more disabling effect, in that they were marginalised for example, but also an enabling effect, where the organisation 'helped' them in their work with individuals diagnosed with 'schizophrenia'. This tends to lean more towards the critical realist epistemology, which in order to be useful not only draws upon discursive practice, but also on Foucauldian discourse analysis and an examination of material and institutional practices (e.g. Willig, 2007).

Similar to the arguments with regards to the hybrid of counselling psychology, it seems as if counselling psychologists may be placed within situations where they are forced to use the empiricist talk of psychology, whilst still attempting to employ the phenomenological view point of their value base. However, there also appears to be an element of marginalisation and what Marshall (2004) referred to as the divide between the 'psychotic' and the 'neurotic', whereby there appears to be a discourse present that argues

against counselling psychologists working with individuals diagnosed with 'schizophrenia'. Given that all of the participants had or currently are working with this client group, it only appeared in certain participants' talk, and will therefore not be representative. However, there also appeared to be talk present where the message was that individuals diagnosed with 'schizophrenia' should not be the recipients of therapy by counselling psychologists at all. One might argue that this relates to the issue of power, and how, as Marshall (2004) outlined, psychiatric diagnoses are 'allocated' to certain professionals while others are not. As stated by Guilfoyle (2002), the places and institutions set up in society, structure, to an extent, what is considered reasonable or appropriate to say and do. So who is entitled to act, how, and in what socially negotiated relationship may be discursively constructed, but this talk also shapes and is shaped by the material settings in which they occur. This relates back to the power of the organisation, and even though the idea of *what* diagnosis is allocated to *whom* may be discursively constructed, there is an element of material power present. This may be what Burkitt (1999) referred to as 'dark' social constructionism, which sees 'discourse as embedded in relations of power that form systems of constraint which regulate social actions' (p.69). Mather (2000) argued that power needs to have a 'locale', for if it does not it can not be critiqued, and if power is everywhere then the idea of resistance makes no theoretical or pragmatic sense. Although one may be able to locate forms of 'counter-discourse' in counselling psychologists' talk, it is important to remember that since they are effectively 'paid mental health professionals' they are also subject to psychopathology as a construct that is crucial to their identities within the organisation. For example, in order to receive referrals and therefore work, as well as being part of the 'team', they may need to draw on the same discursive practice within the institution as more 'medicalised' professions. This may delimit the way in which problems may be understood, and may result in counselling psychologists

falling 'victim to the mystification of medical knowledge in psychiatric vocabulary and discourse' (Hook & Parker, 2002: 52).

Some participants spoke of the organisation as an enabling feature of their work with individuals diagnosed with 'schizophrenia', and although there were elements of 'opposition' stemming from certain professions, the use of supervisors and team support facilitated their work. This, just like the disabling aspect of the organisation, varied from individual to individual, but it is interesting to note that as mentioned in the section on the therapeutic relationship, there may be a shift in how counselling psychologists as well as individuals diagnosed with 'schizophrenia' are viewed within parts of the NHS.

7.3.6 Training as Disabling and Enabling

In line with the organisation repertoires mentioned above, it is also worth mentioning the effects of the training institution on the counselling psychologists. The participants were, of course, of different ages and had different forms of training, however, some of the participants had vivid recollections of how their training had disabled or enabled them in relation to the diagnosis of 'schizophrenia'.

As argued by Rizq (2006), training in counselling psychology produces a considerable amount of emotional strain in the trainee, and in line with what Skovholt and Rønnestad (2003) refer to as a sense of 'ambiguity' in training, one of the more difficult aspects of training in counselling psychology is its 'postmodern' philosophical and epistemological value base. However, for the sake of this research it may be important to consider what the effect of Williams and Irving's (1996) epistemological conflict may have as well. Rizq's (2006) notion of a truly 'postmodern' philosophical and epistemological value base in

counselling psychology is in itself questionable when considering this, for as demonstrated by the participants' talk, there always seems to be an empiricist discourse present which would negate the postmodern. Seeing as counselling psychology focuses on the therapeutic relationship it can be assumed that many counselling psychology programmes focus on a relational aspect of therapy, however, as expressed by many of the participants there was a distinct lack of teaching on 'schizophrenia' and working with these individuals. Is this because training programmes are also staking a claim in the 'psychotic/neurotic' divide and staying with the more 'traditional' presentations in seen in counselling, such as 'depression' and 'anxiety'? Or could it be because counselling psychology training programmes too believe that the relationship has no place in therapy that concerns individuals diagnosed with 'schizophrenia'? Jensen (2006) conducted a study on the influence of the medical model on counselling and psychotherapy training programmes in America and found that the influence is inevitable, however, that how the training programmes approached the medical model varied.

While some participants attributed blame towards training organisations and seemed to argue that the training process essentially 'closed down' the opportunity to work with this client group, others seemed to take the view that *what* was learnt, with regards to relational techniques and ways of looking at client experiences helped them in their work with individuals diagnosed with 'schizophrenia'. So there appeared to be ambivalence about how the training organisations approached the diagnosis and an almost implicit 'transmission' of skills needed to work with the client group. However, it was also clear that working with this client groups was very much up to the individuals themselves whilst training, and appeared to be spurred on by a personal interest in working with the client group, or wanting as much

diverse experience as possible and once having completed the placement, actively seeking out work in the area.

7.4 Reflexivity: A Critical Appraisal

Perhaps the greatest limitation with the reflexive aspect of this research project is that the researcher is, ironically, still too close to the research. As noted by Mauthner and Doucet (2003), the more ‘reflexive’ aspect of the research came after having distance from their own doctoral projects: ‘is there a limit to how reflexive we can be, and how far we can know and understand what shapes our research *at the time of conducting it* [italics in original], given that these influences may only become apparent once we have left the research behind and moved on in our personal and academic lives?’ (Mauthner & Doucet, 2003: 415). Also, as pointed out by Lynch (2000), reflexivity remains a central yet confusing topic, and that it sometimes can be difficult to establish what is being claimed. However, even though it seemed like the research itself benefited by reflexivity, such as introducing the author and therefore the context of the research, as well as by providing an account of how the research developed, it sometimes seemed difficult to know how much to include and if this seemed ‘relevant’ to the research. Or as discussed by Atkinson (2000), the ability to move between an understanding of how much the research was shaped by the author, and how much the author was changed by the research, without falling into ‘infinite regress’ (Gergen & Gergen, 1991) was one which sometimes felt difficult to grasp fluently.

When considering the need to balance critical thinking with the right amount of accountability without wallowing in subjectivity, whilst still engaging the reader (Finlay, 1998), this seemed a task that was easier said than done. As Finlay (2002b) put it, it really is a case of ‘negotiating the swamp’. Parker (1994) asked who exactly the subject is that we are

supposed to be getting closer to through reflexivity. Who is it that is accountable? He distinguished between three different 'subjectivities', namely: 'uncomplicated subjectivities', which refers to the humanist view of the subject as an active reflective agent; 'blank subjectivity', where individual experience is dismissed as a fiction, and is instead considered to be just another discourse; and, 'complex subjectivity', where a combination of the previous two forms takes into consideration the intentions and desires of the individual as well as the operation of social structures and discursive forms. For Parker it is important to 'ground' reflexivity in context:

'The way that social research is contextualised now will also look a little more complex, for the "context" is, in this account, not an objective background against which the researcher renders an account of the phenomenon in question. Rather the context is the network of forms of subjectivity that place contradictory demands on the research...there is an array of competing interests and agendas that frame the production of proposals; the expectations and demands of "subjects" or co-researchers; and the career investments and projected autobiographies that exist in tension in the academic world' (Parker, 1994: 250).

Qualitative researchers who are interested in engaging reflexively must therefore attend to their discourse, which is the rhetoric used to produce accounts of researcher involvement, the research process itself and the analysis of the phenomenon under investigation (Gough, 2003).

In presenting how the research idea developed and evolved, there is an inherent difficulty in attempting to balance the notion of seeming too 'interested' with appearing to be

completely biased (Harper, 1999). For as mentioned above, the closeness of the research is important to consider as the researcher has been completely immersed in the topic for over three years, and perhaps more reflexive elements will emerge when stepping away from the topic. However, it was of course held in mind that the effects of the researcher on the participants would play an important factor in the research. It was clear that some participants saw the researcher as a fellow counselling psychologist, and some even asked for an opinion in the interview on what was being discussed. Another important contextual factor was the place of the interviews, which were mostly held in the participants' place of work. This in itself affected the course of the interviews and was particularly noticeable in how certain participants would change their tone of voice when speaking about 'sensitive' matters. However, how much of an effect this had on the unfolding interviews is a matter of speculation because of the impossibility of having a form of 'benchmark' from which to compare.

7.5 Future Research

Some of the conclusions presented in this research indicate gaps and possibilities for future research. Due to the limited scope of this study, perhaps it could be interesting to 'widen the net' and to explore counselling psychologists' constructions of other diagnoses and the implications these have for their work. The nature of the sample is also one that is worthy of consideration. Interviewing participants that were already situated within the 'discourse' of the NHS provided a good opportunity to explore how their stakes were managed in relation to the diagnosis of 'schizophrenia', however, what may have been of interest is to interview counselling psychologists who have not yet worked with this client group. When the participants referred to issues surrounding 'fear' it was usually in a narrative that preceded their experiences of working with individuals diagnosed with

‘schizophrenia’, which may suggest that interviewing counselling psychologists without this experience would provide further depth for the study. Applying a different methodology, such as grounded theory (e.g. Glaser & Strauss, 1967; Charmaz, 2006) or interpretative phenomenological analysis (e.g. Smith & Osborn, 2003; Smith, 2004) may have yielded a different view on the same topic.

An interesting question that arose from the research concerns the question of ‘causality’. As the research question asked how counselling psychologists construct the diagnosis of ‘schizophrenia’ as well as how they view their ability of being able to work with this client group, this raises the question of whether there is a causal relation. For example, as demonstrated in the literature there does appear to be a ‘causal’ relation between how the diagnosis of ‘schizophrenia’ is constructed and how individuals view their ability or desire to work with the client group (e.g. Gallagher *et al.*, 1991; Servais & Saunders, 2007). As presented in the results, the question of whether the counselling psychologists’ constructions of ‘schizophrenia’ led to a perceived ability to work with the client group or whether working with the client group led to a certain construction of ‘schizophrenia’ is a perplexing question. Or one may ask whether the two notions are indeed too ‘close’ to be able to separate. Similarly, the idea that there is causal relationship between the micro and the macro, or the discursive and extra-discursive as postulated by Wetherell (1998), Walton and colleagues (2004) and Edley and Wetherell (2001) is also problematic.

The use of critical realism as an epistemological base also brings the issue of causality into light and how claims of causality are often exaggerated (Pratten, 2009). For example Lewis (2000) argued that critical realists fail to clarify the causal ‘force’ of social structures, but also concedes that: ‘Macro-social structure exerts a causal influence because the course of

action that people choose to pursue is conditioned by the distribution of vested interests and resources embodied in antecedent social structure' (p.265). However, how does this relate to the idea of 'causality' in discursive psychology? Edwards and Potter (1993) outlined a 'discursive action model' of causal attribution, which is seen as a form of 'action' that constitutes activity sequences such as blame, responsibility and invitation. The difference between the discursive and critical realist forms of causality is that the discursive does not recognise 'material' forms of causality, such as cognitions, and instead places primacy on the use of language, while critical realists argue that the existence of social structures are a necessary condition for the existence of human agency (Lewis, 2000). With regards to this research then, the discursive construction of 'schizophrenia' would be viewed as forms of social interaction that are likely to 'be designed in ways that anticipate their possible refutation or undermining as false, partial, or interested and that they are likely to be designed to undermine, in turn, alternative versions' (Edwards & Potter, 1993: 24). While the critical realist idea of 'schizophrenia' would argue for the diagnosis as a part of a social structure that 'affects' how counselling psychologists talk about 'schizophrenia' through 'a world of antecedent social structures' (Lewis, 2000: 250). However, it is worth noting that even discursive (or anti-realist) theorists have alluded to 'realist' causal factors, such as when Gergen (1999) acknowledged that the statement 'smoking causes cancer' is not necessarily untrue, but then argues that 'smoking causes cancer' is only true within the traditions of science (Nightingale & Cromby, 2002). So this again raises the question whether the 'macro' can indeed be grounded in the 'micro', and whether it is possible to move between them when the causal nature of what they aim to explore are radically different. Pujol and Montenegro (1999) referred to Giddens' (1984) concept of double structuration, whereby 'The emergence and modification of discourses has to be located in participants' agency, in social structure or in the interaction between these two' (p.84), and where an ability to

‘account’ for discourses must include a ‘normative’ dimension (such as power or ideology) and an ‘interpersonal’ dimension (such as agency and interaction).

However, one can discursively reframe the notion of ‘causality’ itself and ask whether asking questions such as these is engaging in hypothesizing of the empiricist kind and whether the idea of ‘causality’ can ever be understood (e.g. Owen, 1995). This debate is an ongoing one and because of space the argument as presented here is one which is incomplete.

7.6 Limitations and Considerations

Perhaps one of the greater limitations concerns methodology and the difficulty in ascertaining what is relativist and critical realist, or what is discursive and non-discursive. Mather (2000) put forward a critique of Foucauldian discourse analysis and stated that critical realists appear to suffer from a desire for ‘ontological security’ in their need to rethink the link between the ‘signifier’, or discourse, and the ‘signified’, or materiality. Similarly, the notion of subjectivity provides a contentious issue, for as argued by Mather, subjectivity is a concept that discursive psychologists question as a taken for granted concept. How this will be managed between the two approaches is still being debated, and the very idea brings what Mather refers to as an unpalatable choice for critical or discursive psychologists who call themselves ‘Foucauldian’:

‘This realization is yet to dawn on the two major trends of critical or discursive psychology currently coalescing around the banners of “critical realism” and “relativism” (or attempting to find the mean between them). This is unquestionably due to the fact that the debate has been largely conducted in terms of whether linguistic statements refer to anything other than themselves’ (Mather, 2000: 95).

Other limitations include methodological aspects such as the use of semi-structured interviews (e.g. Potter & Hepburn, 2005; Wiggins & Potter, 2008), where the researcher becomes the person in power by asking questions and holds an agenda that can limit the interaction and make demands on the participant to adopt a position which they might not have done otherwise. However, it is hoped that the reflexive element has contributed to an understanding that although the researcher entered the research process with certain questions in mind, and having a particularly critical stand towards the research topic, that discourses that had not been considered were included in the write up. However, there is no sense of escaping that as a relatively novice discourse analyst there was an element of what Schegloff (1997) referred to as the importation of the researcher's own categories onto the research process. This relates to the criticism aimed at discourse analysis which argues that because the researcher is both an object of inquiry as well as a source of analysis 'validity' and 'reliability' may be needed. However, as argued by Potter (1996), due to the theoretical assumptions of discourse those types of 'empiricist' notions are more difficult to apply. Potter and Wetherell (1987) stated that reflexivity and some forms of triangulation can be used in order to contextualise the interpretations of discourses during the research process and can further enhance levels of 'validity' in the research. For further research a more 'naturalistic method' (Potter, 2002), such as a group discussion, could be utilised as a more appropriate approach, rather than the 'contrived' nature of interviews (Speer, 2002).

Other 'themes' that were noticed but not included because of limitations of space included talk around the 'fear' of working with individuals diagnosed with 'schizophrenia' and how this fear had diminished over time, and issues surrounding 'stigma'. Perhaps the

transcript can be returned to in order to provide further analysis, and a deeper analysis of the results already presented.

7.7 Conclusions

It was not the author's intention to cast counselling psychology in a negative light or to 'attribute' blame to any of the individuals involved in the research, but merely to explore and critique an area of counselling psychology which appears to have been theorised about *ad infinitum* but severely neglected experientially. Or as stated by Kaczmarek (2006): 'It is past time for counseling psychology to move beyond rhetoric to a more action-oriented definition' (pp.94-95). It seems from this research that counselling psychologists working in, or having experience of, the NHS view their positions with some ambivalence. On the one hand it seems like they contribute something 'different' to the practice of therapy with individuals diagnosed with 'schizophrenia', and on the other hand it sometimes seems like they are in danger of pathologizing the individual further. What must be remembered, of course, is that this not a knowing practice and it must always be considered within the contexts of which they work in. However, what is interesting to see are the inroads that have been made into an area where counselling psychology has been traditionally underrepresented, and time will tell what type of influence this will have on counselling psychology in the future. Will counselling psychology, for example, become more and more medicalised as they move further into the NHS, or will counselling psychologists somehow 'be able to effect changes in the system consistent with our values-from the inside' (p. 515) as argued by Chwalisz (2003)? Perhaps one of the more salient issues regarding this depends on the position taken by the organisations that train counselling psychologists. How will they respond to the growing medicalisation of psychology, and how will they also retain their own philosophical

value base, and by default, their trainees' value base who they release into work upon completion of training?

A question to reflect on is whether if presented with the same opportunity to conduct research into the same topic would 'critical discursive psychology' be used again? The answer to this is 'yes' and 'no'. 'Yes' in the sense that a critical discursive approach would be the most suitable approach for the research question, and the interest in language as productive rather than reflective (Edley, 2001); this view of language allowed a critical appreciation of the diagnosis of 'schizophrenia'. 'No' in the sense that the difficulty encountered in trying to make sense of the two, often conflicting versions of discourse analysis may have resulted in a 'middle of the road' analysis of an important topic, and with regard to future research a more appropriate way of conducting the research may be by looking at the topic using discursive methods and Foucauldian methods separately. With regards to methodology, van Dijk (1997) argued that it is no simple matter to differentiate 'good' discourse analysis from 'bad' discourse analysis, however, what is hoped is that what has been presented here in a 'good enough' (Smith, 2004) discourse analysis. Perhaps one of the most striking aspects of the research is counselling psychology's relationship to the epistemology and methodology employed. In particular, the finding of how critical discursive psychology's epistemological contradictions echo those of counselling psychology's; for as argued by Speer (2007) in her critique of Sims-Schouten and colleagues (2007) critical realist work: 'one problem with such an approach is that the simultaneous pull towards two essentially incompatible epistemologies means that the analyses have a tendency to veer inconsistently between the two' (p.129). Critical discursive psychology is a relatively underused methodology in counselling psychology, and one wonders whether their shared,

confused epistemological value base is one which can be used for their benefit, or whether its absence is a reflection of counselling psychology's own epistemological insecurity.

It is hoped that this research has contributed to the literature on counselling psychology and the diagnosis of 'schizophrenia' by asking questions about how counselling psychologists construct the diagnosis of 'schizophrenia' and how they view their ability to work with individuals in that client group. As stated earlier, this research is not meant to give a comprehensive view of this topic as it is inevitably beyond the scope of this research. However, what this research has aimed to do is to begin to explore an area that is neglected in the counselling psychology literature, and one which at times counselling psychologists appear to have an ambivalent view on. Cooper (2009) asked whether it is possible to see beyond the diagnosis, and referred to Levinas (2003) when he said:

'when the diagnosis is put before the "face" of the client, when the client is seen *as* [italics in original] their diagnosis...then there is a clear "thingification" of the Other: an attempt to reduce their complex unknowable Otherness to the familiar and the Same' (p.122).

Given certain contexts where counselling psychologists currently work, this seems an important and appropriate question. However, it also seems that counselling psychology has an 'inner' struggle to contend with, particularly in relation to its own epistemological conflict, but as raised by Edley (2001) in relation to the realist and anti-realist debate in social constructionism, it is this conflict that keeps the approach radical and 'heated'. As presented by the participants in this research, perhaps the epistemological conflict inherent to

counselling psychology should not be seen as a disadvantage at all, but as a tool that can be used for its own rhetorical effect.

Appendix A

RECRUITMENT INFORMATION

Title of research project: Counselling psychologists' talk about the diagnosis of 'schizophrenia'.

Thank you for expressing an interest in this research. I hope that the information provided below will help you in making your decision of whether to participate. If you do have any questions that may have not been provided for in this brief, please do not hesitate to contact me.

Brief description of research project

The purpose of the research is to explore counselling psychologists' views on the diagnosis of 'schizophrenia', and their perceived ability in being able to work with this client group. Counselling psychologists have not had an active role in working with individuals diagnosed with 'schizophrenia', with the more traditional applied psychology professions involved being psychiatrists and clinical psychologists. However, it is the aim of this research to attempt to understand what possible role counselling psychologists might play in working with this client group.

At the end of the research, I hope to gain a better understanding of counselling psychologists' views on working with individuals diagnosed with 'schizophrenia', and what implications this might have for the practice of counselling psychology.

What are the potential benefits for you and for me?

I am hoping that by talking to you it will be possible for me to gain an understanding of what your views are on the diagnosis of 'schizophrenia', and if you feel you would be able to work with this client group based on your practice and experience. Also, it may be of interest to explore why you might not feel able to work with individuals diagnosed with 'schizophrenia'. Talking about this subject matter is to engage in a debate that is currently ongoing about counselling psychologists' ability to work with individuals diagnosed with mental health problems that are considered severe, and it is hoped that your views, and this research, will make a contribution to that debate. The aim of the research is to allow you to speak about your views on the diagnosis of 'schizophrenia', and to explore its relationship with your perceived ability in being able to work with the said client group. From this I hope to write up the findings for a PsychD.

What will taking part involve?

I would like to interview you for approximately one hour; the interview will be recorded and subsequently transcribed by myself. The transcription will then be read and explored using a qualitative methodology, and from this I will hope to gain an understanding on your position in relation to the diagnosis of 'schizophrenia'.

The findings will be written up in the research, which may be published in part or as a whole.

How will you remain anonymous?

I will ensure your anonymity by coding your transcript with a letter chosen at random, and also excluding all identifying details (names, places, dates etc) from the transcript. I will be the only individual with access to the recorded material and any details provided concerning contact information.

You will also have the choice to receive a copy of your transcribed interview for you to look over and approve before I begin my analysis. This is to ensure that you agree on the transcription, and will also provide an opportunity for you to revisit what was discussed in the interview if you wish to do so.

Are there any difficulties that might arise from participating?

I hope that there will be no difficulties arising from you participating in my research. I will endeavour to be as clear as possible before the interview begins with regards to the procedure, and also to provide some time after the interview if you wish to raise any questions concerning what was brought up in the interview itself. If any questions do come up after the interview you are also free to contact me by e-mail. You will also be provided with details of organisations that you can contact in case you do experience emotional distress from the research process.

Right to withdraw from the research

Withdrawal from the study is possible at any time whereby individual quotes or examples provided by you will be removed. However, the composite nature of the data analysis process means that the later withdrawal occurs in the research process, the more difficult it will be for the researcher to remove the essence of a contribution which may result in data still being included in an aggregate form. If you would like to withdraw after participating in the research please contact me by e-mail referencing the ID number provided at the top of the Debriefing Form in order to ensure anonymity.

I would like to participate, what do I do next?

Please contact me, preferably by e-mail. We can then discuss the research further, which will give you the opportunity to ask any further questions you may have. We will agree on the practical arrangements of conducting the interview, such as an appropriate time and place. I will also send you a Consent Form outlining how I will use the material recorded, which I will ask you to sign and return.

Patrick Larsson
School of Human and Life Sciences
Roehampton University
Whitelands College
Holybourne Avenue
London SW15 4JD

Tel:

E-mail:

Should you have any concerns regarding the way the interview or other procedures have been carried out, please contact either myself or the director of studies. If you would like to contact an independent party then please contact the Dean of School.

Appendix B



PARTICIPANT CONSENT FORM

Title of Research Project: Counselling psychologists' talk about the diagnosis of 'schizophrenia'.

Brief Description of Research Project:

This research will aim to investigate counselling psychologists' views on the diagnosis of 'schizophrenia' and their perceived ability in being able to work with this client group. The intention is to explore what position counselling psychologists have to psychiatric categories, and what implications this might have for the practice of counselling psychology. The research process will consist of an interview lasting an estimated one hour, which will be recorded for later transcription and analysis by the researcher. It is hoped that the research will contribute to the debate on counselling psychology and its relation to working with individuals considered outside their normal range of practice.

Right to Withdraw from the Research

Withdrawal from the study is possible at any time whereby individual quotes or examples provided by you will be removed. However, the composite nature of the data analysis process means that the later withdrawal occurs in the research process, the more difficult it will be for the researcher to remove the essence of a contribution which may result in data still being included in an aggregate form. If you would like to withdraw after participating in the research please contact me by e-mail referencing the ID number provided at the top of the Debriefing Form in order to ensure anonymity.

Investigator Contact Details:

Patrick Larsson
School of Human and Life Sciences
Roehampton University
Whitelands College
Holybourne Avenue
London SW15 4JD

Tel:

E-mail:

Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw at any point. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings.

Name

Signature

Date

Please note: If you have any concerns about any aspect of your participation in this research, or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Dean of School or the Director of Studies.

Appendix C

DEBRIEFING FORM

Title of research project: Counselling psychologists' talk about the diagnosis of 'schizophrenia'.

Thank you for your time. I hope that the interview process was comfortable for you.

The purpose of the research is to explore counselling psychologists' views on the diagnosis of 'schizophrenia' and its implications for practice.

Counselling psychologists have not had an active role in working with individuals diagnosed with 'schizophrenia', with the more traditional applied psychology professions involved being psychiatrists and clinical psychologists. However, it is the aim of this research to attempt to understand what possible role counselling psychologists might play in working with this clients group.

I would now like to offer some time for you to bring up any concerns which may have arisen for you during the interview process.

Is there anything in particular that you would like to talk about that came up from this interview?

Do you feel that you have any further comments or questions before we end for today?

If you do think of anything later, I will be available by e-mail to answer any questions that you may have about this research.

If you felt that any difficult issues came up for you during the interview, then please raise these issues in your next personal therapy or supervision session. Alternatively, you can also contact the organisations listed below for support in case the research process caused any emotional distress:

The British Psychological Society has a list of therapists that can be contacted at:
<http://www.bps.org.uk> or 0116 254 9568

The British Association for Counselling and Psychotherapy has a list of therapists that can be contacted at: <http://www.bacp.co.uk> or 01455 883300

The United Kingdom Council for Psychotherapy has a list of therapists that can be contacted at: <http://www.psychotherapy.org.uk/> or 0207 014 9955

Right to withdraw from the research

Withdrawal from the study is possible at any time whereby individual quotes or examples provided by you will be removed. However, the composite nature of the data analysis process means that the later withdrawal occurs in the research process, the more difficult it will be for the researcher to remove the essence of a contribution which may result in data still being included in an aggregate form. If you do wish to withdraw please contact me by e-mail referencing the ID number provided at the top of this form in order to ensure anonymity.

This research is being conducted by:

Patrick Larsson
School of Human and Life Sciences
Roehampton University
Whitelands College
Holybourne Avenue
London SW15 4JD

Tel:
E-mail:

and supervised by:

Onel Brooks
School of Human and Life Sciences
Roehampton University
Whitelands College
Holybourne Avenue
London SW15 4JD

Tel:
E-mail:

Declaration:

I confirm that the interview was conducted in an ethical and professional manner and that I am happy for the research to proceed using my material.

Name of participant:

Signature:

Date:

Name of researcher:

Signature:

Date:

Please note: If you have any concerns about any aspect of your participation in this research, or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Dean of School or the Director of Studies.

Appendix D

Transcription Conventions

The transcription conventions are the same used in Sims-Schouten and colleagues' (2007: p.123) critical realist account of women's talk of motherhood, childcare and female employment. These in turn are a reduced set of conventions adapted mainly from Gail Jefferson (see Atkinson & Heritage, 1984: ix-xvi).

<u>Symbol</u>	<u>Indicates</u>
◦ ◦	Encloses speech that is quieter than the surrounding talk
(1)	Pause length in seconds. If presented as (.) the pause is too short to measure.
- hyphen	Word broken off
↑	Rising intonation
↓	Lowering intonation
CAPITAL	Talk that is louder than the surrounding talk
<u>Underline</u>	Stress/emphasis
> <	Encloses speeded-up talk
.hhh	In-breath
hhh	Out-breath
[]	Overlapping speech
()	Encloses words the transcriber is unsure about. Empty brackets enclose talk that is not hearable
[Onset of overlapping speech
{ }	Clarification, referring to tone or gesture, e.g. {laughs}
...	Extended sound
=	Marks the immediate 'latching' of successive talk, whether of one or more speakers, with no interval

Appendix E

Sample Transcript

- 1 **Int:** OK, so /erm/ my first question is if you've actually worked with an individual or
2 individuals with a diagnosis of schizophrenia?
- 3 **Par:** Yeah.
- 4 **Int:** [Yeah, can you=]
- 5 **Par:** Yeah, I mean my /erm/ current job is specifically working with people with a
6 diagnosis, if you like, of schizophrenia (.hh) (.) /erm/ (.) and yeah, experiences of,
7 yeah, psychosis, so /erm/ (.) yeah, that's my total role, if you like
- 8 **Int:** [OK]
- 9 **Par:** I've been doing it for about a year and (.) eight months now [**Int:** Yeah] /erm/.
- 10 **Int:** What have your experiences been of that?
- 11 **Par:** /erm/ I mean, >it's something initially I thought well, I'm not interested in going to
12 work with this client group< and /erm/ (2) and then, as I've started, I've absolutely
13 loved it and I don't know if love's the right word but (.h) I mean, it's=I've really kind
14 of (1) I guess it's challenging, it's fascinating, it's /erm/ (.) I guess it can be quite
15 /erm/ (2) I don't know what the word is but quite /erm/ (2) 'draining' is wrong but it
16 kind of, it really tugs at you [**Int:** Mmm] as a therapist, I think, and (.hh) I've met
17 some really interesting people and some, kind /erm/ quite /erm/ complex people but
18 really I find it very interesting and something that I've surprised myself of how much
19 I've actually enjoyed working with people [**Int:** OK] and yeah, it's been a real kind
20 of, yeah, really good experience actually, so...
- 21 **Int:** But a challenging one?
- 22 **Par:** Yeah, definitely challenging /erm/ I think because often people who experience
23 psychosis are often quite traumatised, they've had some very difficult life experiences
24 /erm/ and I think (.) you're not only working maybe with the kind of psychosis-type
25 difficulties (.h) but you've also got other things, you know, that you're kind of
26 working with as well [**Int:** Mmm]. So yeah, I find it quite challenging.
- 27 **Int:** So it sounds like /erm/, it sounds like you're looking more at psychological aspects as
28 well, or, or sort of, you know, their upbringing and things like that?
- 29 **Par:** Yeah, definitely.

30 **Int:** And the actual, sort of, psychosis bit as well? Or is it...

31 **Par:** Yeah, I mean my job role, if you like, was set up specifically by the NICE guidelines
 32 and funding is, kind of on the basis of increasing (.) psychological therapy to this
 33 client group specifically [**Int:** Yeah], and it, I suppose it's aimed at providing CB:T, if
 34 you like, but I guess being trained as a counselling psychologist and quite
 35 integratively [**Int:** Yeah], I struggle to actually work totally in a CBT for psychosis
 36 way [**Int:** Mmm], which I guess would look at /erm/ maybe symptoms more, to some
 37 extent, although that does vary across models [**Int:** Yeah] /erm/ but I think yeah, you
 38 can't ignore, you know, early experiences or kind of traumatic things that have
 39 happened in someone's life and I think it's (1) very much been looking at, kind of, the
 40 meaning of their experiences of the psychosis, what does it mean for them (.) and
 41 their, kind of, relationships with, say, voices /erm/ and kind of understanding that, so,
 42 yeah, I think (1) >yeah, you have to kind of approach it on many different levels [**Int:**
 43 Mmm], I think<.

44 **Int:** So there's sort of a, a technique-based aspect of it=

45 **Par:** [Yeah]

46 **Int:** Like CBT, but at the same time, there's also using some psychodynamic, or
 47 something like that?

48 **Int:** Yeah, >and the therapeutic relationship is just huge, I mean, I think it's hugely
 49 important< (.h) I kind of learned very much at the beginning that if you jump in with
 50 technique, you can absolutely lose someone [**Int:** Mmm] and particularly, I think,
 51 with this client group /erm/ because people are often really preoccupied /erm/ with so
 52 many things, you know – whether it's hearing voices, whether it's seeing things,
 53 having visions and different things – and I think if you try and, you know, go in with,
 54 kind of, 'right, tell me all about your voices', you know, 'write these all down, do a
 55 diary,' you know, all those kind of things, you can really /erm/ (1) I think you can ruin
 56 things and (.h) I think engagement in building that relationship with someone is so
 57 important [**Int:** Mmm], and I've often just put all of that (.) technique aside
 58 sometimes and just (.h) got to know them as a person, you know, think about (.) yeah,
 59 just little aspects of their life, you know, what they enjoy doing, if they've got
 60 interests and that kind of stuff before you go anywhere near, kind of, therapy
 61 {laughs}, if you like, type, [**Int:** Yeah, yeah] you know.

62 **Int:** How have you found that process to, sort of, building that relationship [**Par:** Mmm],
63 how have you found that?

64 **Par:** >I mean, it's been really difficult at times, you know, I've had a client who sticks out
65 particularly< who=we'll just spend ten minutes together and that will be enough,
66 that's all she could tolerate and (.h) sometimes she might just leave the room, you
67 know, without saying what was going on (.h) and until I, kind of, had a chance to
68 build that relationship with her and find out, well, actually, I was turning into some
69 kind of really (.) awful vision, you know, hallucination for her, this really horrendous
70 thing that was really frightening, we couldn't, you know, it took some time to kind of
71 overcome things (.hh) so yeah, and it's also involved (.) a lot more flexibility in my
72 role, so if I worked, say, in a primary care (1) position, if people didn't turn up to
73 appointments, you probably closed them, whereas, you know, this position, you, kind
74 of, °really work hard engaging people, you know, calling people, seeing if they want
75 to come, meeting people maybe at home° /erm/ meeting people in a café↑, it's
76 wherever they feel most comfortable, I think you have to be really, sort of, flexible in
77 the role, definitely /erm/ so yeah.

78 **Int:** >And do you feel as though your role as a counselling psychologist has actually
79 prepared you for that kind of flexibility and that kind of role?<

80 **Par:** Yea:h, I think so, because I think=I suppose through our training, we have=I guess we
81 work in so many different placements, we have to be able to juggle things, we have to
82 (.h) be creative, I think, sometimes and I think definitely /erm/ I think it's allowed me
83 to do that and (1) maybe because there's such a focus on the relationship, I guess, in
84 our training and building that with someone, you know, you don't necessarily feel that
85 you have to (2) kind of be so=yeah, technique-focused all the time=well, I don't know
86 if that's me personally, or if it is because of the training, you know, I think (.) maybe
87 it's a bit of both /erm/ I think, yeah, I think our role (1) maybe surprisingly, does fit
88 really well, I mean, I think sometimes you get this kind of /erm/ =I don't know,
89 maybe at the beginning, people think sometimes=people think, 'counselling
90 psychologist, you know, are they as capable as clinical psychologists,' you know,
91 there's always that kind of (.h) thing maybe going on and I think /erm/ actually, yeah,
92 I think they're really quite well equipped to work with this client group, and in the job
93 I'm in at the moment, and particularly in the trust I work in, there's a lot of

94 counselling psychologists who work within these complex areas so, yeah, actually I
 95 think we are able to do it {laughs}.

96 **Int:** Well, how did you actually find yourself applying for that position? Was that [**Par:**
 97 /erm/], was that a particular interest, or was it, sort of...?

98 **Par:** Yeah, let me think /erm/ what was I doing before /erm/ yeah, I think (2) I guess it
 99 came {laughs} down to a range of things=in fact, I needed at the time, because I
 100 was=when I started it, I was training so /erm/ I needed placement hours /erm/ I was
 101 actually working in another area of the same trust (.), so I had a kind of feeling for the
 102 trust and got to know a few different people /erm/ (1) I don't think initially it was a
 103 great interest, at the beginning, I think it was more (1) 'yeah, let's give it a go.'=I'd
 104 worked in a home treatment team in crisis situations with people before, so it wasn't
 105 totally alien or anything /erm/ you know, the kind of client group /erm/ but maybe I
 106 thought yeah, therapeutically it'd be good to work with people a bit longer term /erm/
 107 (2) and yeah, get a feel of a different client group, so yeah, I guess I was coming from
 108 a slightly not knowing kind of position, kind of intrigue and interest in working in it
 109 /erm/.

110 **Int:** But you started there as a trainee, you are saying=

111 **Par:** [Yeah]

112 **Int:** In the same role that you have now?

113 **Par:** Yes, yeah /erm/...

114 **Int:** [What was that like for you when you sort of started out? You hadn't qualified, was
 115 it?]

116 **Par:** Yeah /erm/ well I guess I was in my final year=was I in my final year {laughs} I'm
 117 trying to think, what year was I in, I was in my third year and then I had my fourth
 118 year, yeah, so I didn't feel=I don't think I felt (.) too scared by the prospect that /erm/
 119 I think what really helped was my supervisor in the role, I think /erm/ I guess I didn't
 120 know that till I started, but (.h) /erm/ he was really supportive /erm/ (.) and really kind
 121 of=yeah, I felt really comfortable and really supported by his supervision, so I think
 122 that really helped actually (.h) /erm/ and initially, I started the job part-time (.) and so
 123 I gradually kind of got into it, I suppose, and then went full-time after a year so /erm/
 124 when >I finished my actual kind of=yeah, you know, university course work and all
 125 that kind of stuff, so I had the time then to really give more to it.<

126 **Int:** Sure, sure.

127 **Par:** /erm/ yeah, so I think that worked quite well, actually, yeah.

128 **Int:** What were your sort of initial impressions when working in that kind of environment
129 with that kind of client group?

130 **Par:** [/erm/]

131 **Int:** Do you recall any?

132 **Par:** °Initial impressions, let me think° /erm/ (2) >I think maybe there was that kind of<
133 /erm/ yeah, there is maybe a little bit of fear, maybe, or kind of=not fear, maybe that
134 kind of (.hhh) pressure that there's an awful lot going on in the room because, you
135 know, people are maybe sometimes distracted, preoccupied, you know=like I said
136 about that engagement, that they're only willing to stay for fifteen minutes and I'm
137 like, well, I'm meant to do fifty minutes, >I'm meant to be a sixty minute {laughs}
138 therapy hour<, kind of thing or whatever, and you think, you know, I'm failing
139 maybe, what am I doing wrong, why aren't they staying with me for an hour, kind of
140 (.h), so I think there is that anxiety at the beginning /erm/ because, yeah, it really was
141 quite different to, say, other places that I'd had, you know, even=you know, I'd
142 worked in long-term (.) sort of, secondary care, which I guess is quite complex cases
143 as well but these people would be there for an hour and fit, if you like, that kind of
144 way of working, but /erm/ so initially, I think it was a bit like, yeah, quite scary, what
145 am I doing wrong /erm/ and really taking a step back and thinking, OK, I need to
146 approach this a bit differently /erm/ and not in perhaps the way I normally would, so
147 yeah, I think supervision was really, really important in the beginning, I mean, it's
148 always important but I think it (.h) kind of gave me the permission, well actually, you
149 don't have to sit there for an hour you can /erm/ (1) yeah, you can=I don't know,
150 yeah, you just=you kind of approach it flexibly and for that person and just take your
151 time with things, I think.

152 **Int:** So that's being adapting, like you said before, being flexible and adapting to this
153 client group?

154 **Par:** Yes, definitely, yeah, hugely important I think /erm/ so I think that probably struck
155 me the mos:t /erm/ ↑maybe, I guess, well, people are very different, which I suppose
156 you can't generalise and /erm/ and I think, yeah, I suppose (.h) maybe the diagnosis of
157 schizophrenia, it comes with huge stigma, I think /erm/ when you first go into it (1)
158 you kind of learn and (.) I guess you go in with your own kind of preconceptions and
159 things and I don't think I was particularly fearful of the general stereotypes that you

160 do find maybe out in the general public, you know, of the kind of attaching violent
161 and, kind of, aggressive labels which people often do, that didn't really=I don't think
162 that was ever there >because I guess I'd worked in a home treatment team and had
163 very different experiences<, °so that didn't particularly come up for me° /erm/ (2) but
164 it was more maybe the kind of complex complexity, you know, having (.) lots of
165 things maybe and wondering, what do I work with, you know, what, is it we work
166 with voices, is it that we (2) talk about, you know (.) difficulties that a person's
167 having, because often there's other things like social difficulties, you know,
168 difficulties with asylum::m, there's often so many other things that kind of come into
169 it as well.

170 **Int:** So in a way, sort of, where does this start or where do you start, perhaps, with...?

171 **Par:** Yes, definitely, and I think it's that real taking a step back, taking your time, getting to
172 know the person in the relationship, I think, and then gradually I guess you find your
173 way /erm/ and maybe you identify goals, maybe initially you can't even go anywhere
174 near that kind of stuff /erm/ it's, yeah, it's real kind of small steps I think.

175 **Int:** It sounds like it's a very holistic approach in a way=

176 **Par:** Yeah.

177 **Int:** Encapsulating quite a lot in your work.

178 **Par:** Definitely, and I think because I work in a CMHT /erm/, you know, often the people
179 that (.) are referred to me have care co-ordinators and they (.h) have, I guess, other
180 needs so hopefully, you can=it's really important to work as a team, I think, and /erm/
181 I guess you'd do that more so than, say=yeah, I guess obviously more so than in
182 primary care and that kind of thing /erm/ but you kind of (.), you know, you spend
183 time talking to their care co-ordinator, you spend time talking to the psychiatrist, you
184 know, you work in a much more, yeah, kind of holistic way, yeah, I mean, I think (.h)
185 what I've learned a lot in this job is that it's not just working with the client and often
186 a lot of the work's done with other people (.) and needs to be done with, say, other
187 elements of the service /erm/ you know and I think that's been really a big part of my
188 role as well /erm/.

189 **Int:** How's that worked, communicating with those kind of medical professionals=

190 **Par:** [Yeah]

191 **Int:** or what you might call them?

192 **Par:** >Really interesting, I mean, I think supervision again was really useful< because my
193 supervisor's very kind of=comes from quite a social constructionist perspective, kind
194 of not really /erm/ doesn't really favour, I guess, diagnosis and the kind of
195 usefulness=uselessness I guess of that, yeah, and /erm/ I find that very kind of=that
196 was quite supportive to have him there, if you like /erm/ so then when you kind of=I
197 guess you have psychiatrists that are, yeah, kind of, quite focused in a more medical
198 model approach and (.h) they're kind of working with a person very much in the
199 medical way, and so you do kind of come across (1) frustrations and, kind of, maybe
200 differences of opinion (1) and (.) gradually I found my confidence and ways of, kind
201 of, approaching and working with that /erm/, but I guess it varies with different
202 psychiatrists and /erm/ (2) you can be pleasantly surprised and, you know, in different
203 things, you know, like I was today, you know, a psychiatrist approached me very
204 differently and (.h) so I think it can be challenging /erm/, but sometimes I feel like
205 you can be a bit of a voice maybe for the client, you know, who might struggle to
206 (.hh) actually communicate in a CPA meeting that actually, these are things that are
207 going on and, you know, they want changes in the medication, whatever, that you can
208 maybe kind of support them and enable them to do that /erm/ so, yeah=I don't know if
209 I've just waffled off somewhere, but, yeah.

210 **Int:** It sounds like, sort of /erm/ well=what I was going to ask, what sort of camp would
211 you fall in? Are you more social constructionist, or more=

212 **Par:** [Yeah]

213 **Int:** Or more medical, or in between, perhaps, or...?

214 **Par:** I mean, I really don't (1) fit with the whole /erm/ genetic medical idea of
215 schizophrenia, that doesn't fit for me at all and (.hh) I don't think a diagnosis has a
216 particularly useful role (.hh), although saying that, yeah=maybe I've contradicted
217 myself slightly, I think some clients quite like a diagnosis sometimes, and maybe
218 that's quite rare /erm/ but sometimes it fulfils something for them when maybe there's
219 nothing else to do that, and then, I guess (.) maybe::e meeting and having time to talk
220 and think about their experiences, (.h) then they're able to construct their own kind of,
221 I guess, narrative or, kind of /erm/ description of what they've actually been through
222 and maybe why it's, kind of, come out in this way and why they're having, you know,
223 kind of, experiences of hearing voices and make sense of it=so maybe initially, a
224 diagnosis makes sense of it, but then maybe actually, hopefully, we can think about it

225 in a more=in a broader way and (.h) in a way that maybe fits them better /erm/
226 because I really do think diagnosis can be really stigmatising, it can be (.h) really
227 quite /erm/ awful for some people and >particularly with schizophrenia< because it
228 think, you know, it leads to the prescription of some really nasty medication that can
229 be really damaging to someone's bod:y, it can cause horrendous side effects /erm/
230 and, you know, withdrawal and god knows what=that medication can be horrendous,
231 so schizophrenia (.h) as a label, comes with a lot of stuff, it's, it's quite a powerful
232 label so I guess I am more towards a social constructionist way, you know, in a way
233 and I think it's more about trying to understand the meaning of someone's experience
234 and /erm/ (2) making sense of it for them, really, what fits for them, how do they feel
235 comfortable in understanding what's happened to them in their lives, and thinking
236 about, yeah, the role of their family, the role of their culture, you know, I certainly,
237 particular with the client group where I work in [] /erm/ you have to consider other
238 elements of people's lives and, you know, that might be culture and religion and all
239 sorts of different things [**Int:** Yeah] /erm/ and often, it can clash with the medical idea
240 because often it can involve being possessed by jins and different things, so you need
241 to hold all of that, I think, and be able to work with those ideas as well as (1) taking
242 into account that they've been in a (.) psychiatric system for many years and have
243 been told that they have an illness, so you've, kind of, °got so many different things
244 that you need to work with, I think°.

245 **Int:** Yes, it sounds like it's quite complex, because I mean=

246 **Par:** [Yeah]

247 **Int:** like you say, it's almost as if they're being possessed by a jinn=

248 **Par:** [Yeah]

249 **Int:** or whether they might be, if it has a very cultural connotation=

250 **Par:** [Mmm]

251 **Int:** maybe it's a way of coping or trying to understand their condition so=

252 **Par:** [Definitely]

253 **Int:** but perhaps sometimes that clashes with the medical model=

254 **Par:** [Yeah]

255 **Int:** which is very sort of...that's just all it is and it's a condition, and the jinn bit is
256 actually a part of their disease or illness, or whatever you might call it.

257 **Par:** Yeah, yeah. because they think, well gosh, it's, you know, a religious delusion or
 258 something, that's I guess how the medical (.h) way of looking at it would be, but=and
 259 even with different members of the family thinking, you know, one thinking it's a
 260 jinn, someone else thinking it's something else (.h), you know, for a person, it can be
 261 (.) quite hard to make sense of because they've got so many different things they're
 262 being told or, kind of (.h) /erm/ so yeah, I think, (1) yeah, it's not, I guess, yeah,
 263 there's a lot of things to balance, I suppose, yeah.

264 **Int:** Well I was wondering, when you were doing your training and you do your sort of
 265 initial placements as well as the training=

266 **Par:** [Yeah]

267 **Int:** did you feel that they sort of prepared you in any way for your work with this client
 268 group?

269 **Par:** No, not at all, I don't think=well, I mean I guess, well, that might be a bit unfair (1)
 270 we didn't have any specific training or lectures, I guess, on this client group at all
 271 /erm/ which now I think, is very disappointing /erm/ but maybe it could be something
 272 that could change in the future, >but I suppose< other areas (.) have prepared me, and
 273 I guess my general training and, you know, working in relationships and that, and the
 274 fact that I guess a lot of our work, we can transfer into different (1) areas, you know
 275 we can use it with different client groups /erm/ even if we haven't specifically focused
 276 on, you know, that in detail=so I suppose yeah, initially saying 'no' /erm/ is a bit
 277 extreme but /erm/ it would've been nice to maybe have had a bit of an introduction to
 278 working with this client group /erm/ and maybe more complex (.) cases because, you
 279 know, I really don't think we did and it really came down to my actual placements
 280 and learning, kind of, within that, I think.

281 **Int:** So learning on the job=

282 **Par:** [Yeah]

283 **Int:** pretty much?

284 **Par:** Yeah, definitely /erm/ >but then, maybe I did feel equipped to do it and able to do it
 285 because< of my experiences in different placements (.h) and the overall training, you
 286 know, gave me that confidence to think, well actually, I do have the skills and abilities
 287 (.h) but /erm/ it would've been nice to have had perhaps some specific /erm/ focus, I
 288 think, on it.

289 **Int:** What would've been helpful?

290 **Par:** /erm/ maybe just even=yeah, a lecture on people's experiences and I guess what
 291 psychosis is, you know, although I mean, I guess I did have=I worked in a home
 292 treatment team as a support worker even before I started my training, so I'd come
 293 across it before so I had a bit of knowledge about it, but maybe for other people, to
 294 kind of say, well actually, you can work with different client groups and more
 295 complex client groups, it's not, you know, something that's kept for other
 296 psychologists, you know, that, it's something that is possible /erm/ and maybe=I
 297 mean, I think now, because I see the value so much of actually service users'
 298 experiences and their, kind of, stories and how actually hearing from them can be a
 299 really good /erm/ way of, you know, learning and understanding something, so maybe
 300 even asking service users to come in and actually talk to trainees and, you know,
 301 /erm/ you know, °describe their experiences and things might be a good way of doing
 302 it /erm/ so yeah, I think, yeah, it would've been good to have something like that°.

303 **Int:** And did your, sort of, colleagues think so as well? Or was that, what was the general
 304 feeling=

305 **Par:** [Yeah]

306 **Int:** on the course, you were very, kind of...?

307 **Par:** I don't think there was anyone else on my course who worked in this area or had a
 308 placement /erm/ I know someone now who's doing her thesis actually on psychosis as
 309 well, and I think she's got an interest but I don't think she's working in that /erm/ but
 310 I think it may have been seen as=I don't want to make assumptions here, but maybe
 311 that it is an area that's quite (.) specific, if you like, and /erm/ maybe, yeah, maybe it,
 312 yeah, they had some interest but because they hadn't worked in it before, they hadn't
 313 had any training or lectures or anything, then kind of didn't go near it somehow,
 314 maybe↑ (1) yeah.

315 **Int:** So it sort of wasn't actually made (.) available, in a way?

316 **Par:** >Yeah, yeah<, maybe it's a bit too=yeah, you kind of feel you need a bit more, what's
 317 the word (1), yeah, there wasn't even a lecture on it or, you know, that kind of stuff, I
 318 think, for people's interest=and maybe, is it that it's=yeah, like clinical psychologists
 319 and people who deal with that kind of area, you know, maybe that more traditional, I
 320 don't know (.) thing.

321 **Int:** That's what I was going to ask you because you said before as well that (.), you know,
 322 it seems like you've sort of been allocated to other psychologists [**Par:** Mmm] in a

323 way and for counselling psychologists, it's actually not that (1) >relevant< or current,
 324 or whatever way=
 325 **Par:** [Yeah]
 326 **Int:** you want to put it, so is that, is that how you felt about it as well, that, you know, on
 327 your course [**Par:** Mmm], those kind of conditions like schizophrenia [**Par:** Mmm] or
 328 several mental health problems have been sort of, you know, pushed away? Sort of,
 329 we don't work with them=
 330 **Par:** [Yeah]
 331 **Int:** we work with depression or people who have more adjustment problems, or is that
 332 what it was like, maybe?
 333 **Par:** /erm/ I think maybe in the first couple of years when I was training, it was=yeah,
 334 maybe in a primary care, depression, kind of gentle stuff {laughs}, which is probably
 335 unfair because (.h) it's often quite complex /erm/ but (1) /erm/ (2) so maybe initially
 336 /erm/ a thought came to my head and it's kind of gone /erm/ (3) but yeah, I was
 337 thinking about, like, working with children, you know, you actually think 'oh,
 338 counselling psychologists don't work with children', but actually, they do and a
 339 couple of my fellow trainee::es, you know, they did placements with working with
 340 children (.h) so actually, it's like, you know, counselling psychologists (.) in my
 341 training were broadening, if you like, the remit {laughs} or whatever that we can
 342 work in /erm/ [**Int:** Yeah] so initially, maybe it did start of like that, but then maybe
 343 because, you know, I'd worked in different settings as a support worker and I
 344 did=I've kind of tried out different groups like learning disabilitie::s, you know, I felt
 345 well actually, why not , why not try=yeah, schizophrenia or whatever, you know,
 346 these different /erm/ and yeah, I guess, some of the other trainees as well, they were
 347 working with maybe more specific things like chronic fatigue and so that was, kind
 348 of, happening, and even now, one of them has got a placement in a gambling service,
 349 so I think it's showing that actually we can work in a variety of different ways and
 350 different places, and with different groups and (1) since I've worked in this trust, like
 351 I said earlier, it's kind of, I've met quite a few counselling psychologists now who are
 352 working with complex mental health difficulties and, you know, so=and another
 353 trainee who's in the same job as me, so it's not such a strange thing to do, I don't
 354 think.

355 **Int:** Well, it sounds very much like it's up to the individual (.) sort of up to your own
 356 interests to=
 357 **Par:** [YEAH]
 358 **Int:** your adventurousness, willing to try (1) working with different client groups.
 359 **Par:** Yeah, I think so, and I think=I guess we've all got our own little interests, haven't we,
 360 I suppose, and maybe areas we feel more (.) intrigued by or challenged or
 361 comfortable, I guess, yeah, so maybe there is an individual thing, but I think (1) when
 362 services support it, because I guess the trust I work in /erm/ (2) you know, that they
 363 ask for trainees to come and work in the, kind of, more /erm/ complex psychology
 364 service, I guess (.h), you know, they're actually saying yes, you can work with this
 365 client group and they're, kind of, yeah, we want trainees >so that's kind of saying,
 366 it's sort of opening it up a bit< /erm/ and then maybe from that, you kind of get to
 367 experience more complex difficulties, so it does help, I think, when services out there
 368 kind of (.), you know, advertise or open things up a bit.
 369 **Int:** Or it's encouraged to try that out...
 370 **Par:** Yeah, definitely, yeah.
 371 **Int:** Was there anything in particular for you that, you know, that sparked your interest
 372 about working with schizophrenia? I mean, you said you'd worked before with=in
 373 the community, is that right?
 374 **Par:** Yes, I'd worked in a home treatment team which, I guess, is quite crisis led, so the
 375 actual therapeutic work, at that point=I was a support worker but had some
 376 supervision by a psychologist=so I guess it's more of an assistant psychologist's role
 377 really, although I wasn't being paid that {laughs}, but it kind of (1) inspired me into
 378 the more complex difficulties and, kind of, the real distressing situations people can
 379 find themselves in (.h) /erm/ (1) and I'd worked in learning disabilities which again, I
 380 guess, can be a really (1) I don't know, you either kind of like it or don't {laughs} like
 381 it, I think, maybe, so yeah, (.) I don't know what really inspired me with this job
 382 {laughs}, actually, initially, it's really hard to think back then /erm/ (2) I know now
 383 what I like about it, you know, what I enjoy=I don't think 'enjoy' is the right word,
 384 but (.) I think meeting such a range of (.h) maybe (.) different people but kind of,
 385 trying to make sense of these experiences which I think are almost (1) quite creative, I
 386 don't know, ways of the mind coping with their life, you know, and I think people
 387 have had such terrible experiences but somehow, the kind of psychosis is somehow is,

388 kind of (2) the way of, kind of, coping with those, you know, and it's a way of
 389 (1)=and then trying to understand that and finding ways to help them to get on with
 390 their life, maybe still have these experiences [**Int:** Mmm] is really quite fascinating,
 391 kind of, yeah, (2) it feels quite satisfying, I think, to see just even small changes, you
 392 know (.h) and actually I think, understanding that actually, these experiences aren't (.)
 393 just for a specific number of people in the population, you know, they're actually
 394 quite common, so many people have these experiences and actually manage to live
 395 quite normal lives and get on with their lives, it's, kind of, working their way through
 396 the distress and the kind of psychiatric system, which can often cause more problems
 397 and then, finding their way out to recovery as well. Because I think the whole
 398 recovery movement and the whole service user movement at the moment is really
 399 opening things up for people with a diagnosis of schizophrenia, I think it's really
 400 allowing other options rather than, 'you're going to have to stay in mental health
 401 services for the rest of your life on these medications', you know, and not really have
 402 a life, as such, it's actually allowing a lot more things to change, it's really good.

403 **Int:** And do you feel, sort of, part of that in any way?

404 **Par:** Yeah, I really do, and I think this job has helped that /erm/ I think it's really helped
 405 me develop as a therapist, it's really enabled me to feel more confident and able to,
 406 kind of, find my way and how I like to work, and I think this job's really enabled that,
 407 definitely /erm/ (2) yeah, and I think enabled me to actually respect a service user's
 408 experience a lot more, I mean, I think I always have done, and you always place them
 409 as=they know, they are the expert. But I think this has enabled me to kind of realise,
 410 well, we can actually learn so much more from them and find their way, °if you like,
 411 to recovery and things a lot more°.

412 **Int:** So in a way, consider using their experiences for their benefit in a way, or=

413 **Par:** [Yeah]

414 **Int:** as much as you can=

415 **Par:** [Yeah]

416 **Int:** there is a line between sort of distress and being able to (.) live with their symptoms=

417 **Par:** [Yeah]

418 **Int:** and with their illnesses, so perhaps trying to find a bit of a middle ground to work
 419 with so they can cope with it, is that...?

420 **Par:** Yeah, I think so, definitely and I think=like, one guy I worked with, he's had this
421 really strong belief (.) for over fifteen years that there are people out there watching
422 him and monitoring him, and /erm/ also having an impact on the other people around
423 him (.h) {coughs} and I guess he's had this for many years, you know, and he'll really
424 isolate himself and sometimes he'd hear voices in relation to it, but it's had such
425 derogatory impact on him /erm/ in his life, but now he's managed (.) to find a way to
426 live a life, but also still have that there, so we haven't managed really to shift that an
427 awful lot, you know, there's a slight movement in it that he's sort of able to, kind of,
428 let go slightly, if you like, but he's actually able to have a life, to make music, to start
429 up his own, kind of, little business selling music and doing stuff and going on holiday,
430 and kind of doing more things he'd like to do, even though there's this horrible kind
431 of, well, for him, horrible, this horrible thing hanging over him that, you know, there's
432 some people out there /erm/ so it's kind of, ↑and I don't know what point I was really
433 making there {laughs}, yeah, I think it's just that kind of enabling people to, kind of,
434 yeah, you're not going to do the medical cure, if you like, but actually they can have
435 some pleasure and some satisfaction in their life, which is really, really good to see, I
436 think, yeah.

437 **Int:** But at the same time, it sounds like quite challenging work, being able to=

438 **Par:** [Yeah]

439 **Int:** shift those kinds of things that are quite ingrained, in a way or...

440 **Par:** Definitely, and you have to realise that you probably won't ever, almost, you always
441 have to start sometimes in that position, more 'no, that might not ever change' but
442 how can that person's life be different, or more /erm/ enjoyable for them, if you like
443 /erm/ and I think for a lot of people, it's a bout believing them, I think, because there
444 is that whole thing that 'oh no, you can't' /erm/ what's the word they like to use in
445 medical, oh, I can't think of the word now, but you can't say their experiences are real

446 **Int:** Oh, yeah, collude.

447 **Par:** Collude, that's the word, I hate the word {laughs} you know, because oh no, you
448 can't collude with them, it's just the wrong thing to do but actually, so many people
449 I've worked with, that sense of being believed is just huge because they're constantly
450 facing people who're saying 'you're ill, it's not real, it's just rubbish', you know, all
451 this kind of stuff, and that's just horrendous, you know, that experience for them, I
452 think the fact you're alongside them and you're kind of with them in that experience

453 and able to support them, is so, so important (.) and then it enables them to get into a
 454 position to start thinking, ‘well actually, you know, yeah, how can I make sense of
 455 these experiences, how can I try and understand them’, and, you know, kind of cope
 456 with them differently, maybe /erm/.

457 **Int:** So it sounds a little bit like detective work, in a way, or a puzzle=

458 **Par:** [YEAH]

459 **Int:** Or something like that.

460 **Par:** Definitely, I think you really have to try and make sense of it and I think it can take a
 461 really long time just to even (.h) unpick a little bit, you know /erm/ and >because it’s
 462 quite scary to do that< because often, it leads back to some really distressing
 463 experiences and, you know, even with some people, you don’t even get to name those
 464 experiences because it’s just too painful to go near it, but you’re kind of starting to
 465 make a bit more sense of it, and particularly feelings=I think for a lot of people, anger
 466 has come out as being quite a prevalent emotion, if you like, that people are struggling
 467 with but actually, kind of (.) gets pushed away somewhere and the focus then is really
 468 on these other things, like the voices or the voices are communicating the anger for
 469 the person, or they’re kind of, you know, away, so I think it is really trying to make
 470 sense of the psychosis that’s at the surface level with what’s going on underneath it, I
 471 think.

472 **Int:** so there’s something about getting actually to the affect, [Par: Mmm] what’s lying
 473 underneath in a way, the feelings that they have, but then that is communicated=

474 **Par:** [Yeah]

475 **Int:** through paranoia, perhaps, or voices or whatever it might be=

476 **Par:** Yeah, and I think actually, I mean, I’m reading bits and things at the moment, like the
 477 voices are like metaphors, like they represent certain things and it is really trying to
 478 understand that, which I guess the diagnosis of schizophrenia doesn’t do, it °doesn’t
 479 try and make sense of someone’s experience, you know, it really is just keeping it in
 480 that illness, they’re ill, kind of thing°, but actually there’s way more to it than that
 481 /erm/ yeah.

482 **Int:** Right, so the final question is=

483 **Par:** [Yeah]

484 **Int:** if...in what ways, if any, might a diagnosis sort of affect the way you work with a
 485 potential client or with a client?

486 **Par:** Yeah, that's a=do you mean, like, if you get given that first....

487 **Int:** Yeah, exactly how you sort of....I mean, you covered it a little bit, I guess, with the
488 other questions=

489 **Par:** [Yeah]

490 **Int:** but whether it's sort of that impact of the label or the diagnosis?

491 **Par:** I suppose no, it doesn't really, I don't (.) get=because I=yeah, I suppose, although
492 people=I suppose it's a struggle in the role I'm in because I can only see people with
493 that diagnosis, so I guess you're, in a way, eliminating (1) other people who may have
494 similar experiences but have a different diagnosis, so say they have depression with
495 psychosis, you can't see them, supposedly, so you're kind of in a way, you're
496 eliminating certain people but I suppose once I've got past that in a way /erm/ I don't
497 know, I guess it's there (.) but I kind of put it to one side and start seeing and trying to
498 understand who they are and=because everyone I see who has that diagnosis, they're
499 all so different, you know (1) and now it doesn't really mean much to me, I don't
500 think, I guess it can=well, it communicates a lot because I suppose it communicates
501 this person maybe have been in the psychiatric system for a while, they may be on a
502 lot of medication because of this diagnosis, they may have had (1) well yes, it does
503 communicate something, but then you can't jump to conclusions, I suppose you need
504 to find out for yourself, but yeah=I think I often put it aside and try and understand
505 what that person.

506 **Int:** So it sounds like there's a bit of a conflict between what the diagnosis communicates,
507 saying that being in the system for a long time=

508 **Par:** [Yeah]

509 **Int:** perhaps being cognitively impaired or something like that, but then at the same time,
510 wanting to (1) not judge or fix them, actually meet them and see what they're like as a
511 person=

512 **Par:** [Yeah]

513 **Int:** and sort of that struggle between the two?

514 **Par:** Yeah, I mean, I think I see the diagnosis now more as a (1) kind of paper, not paper
515 exercise, but more of a=I need to see people with a certain diagnosis because that's
516 what my job tells me to do, kind of thing, but OK, fine, I've got that person now, let
517 me see them as a person so it kind of=yeah, that's probably how it is, much as I'd go
518 with the diagnosis, you know, I'd want to meet them /erm/ because >often, people

519 don't even fit the supposed diagnosis {laughs}, you know, they don't even tick all
520 those boxes that they're meant to tick<, you know, so I don't really use it particularly
521 /erm/ yeah, I mean=there's something else that came into my head=yeah, one thing
522 I'm often into is what people themselves make of their diagnosis. I do often ask that
523 and try and see what it's meant to them, how they've used it, the effect it's had and
524 those kind of things and, yeah, because often people sort of say, well, I'm not ill or,
525 you know, I'm not all these=I guess it's=yeah, I think it's quite interesting, just to
526 explore that with someone as well.

527 **Int:** So you'd say for some people, it's quite (.) helpful [**Par:** Mmm] because it explains
528 their symptoms=

529 **Par:** [Yeah]

530 **Int:** and they have a diagnosis of schizophrenia so that's all right=

531 **Par:** [Yeah]

532 **Int:** in common with a lot of different diagnoses=

533 **Par:** [YEAH, EXACTLY]

534 **Int:** such as this one=

535 **Par:** [Yeah, definitely]

536 **Int:** /erm/ But with other kinds, they might sort of internalise that and become like a
537 victim of the system=

538 **Par:** [Yeah]

539 **Int:** or something like that=

540 **Par:** [Yeah]

541 **Int:** or however you want to put it, and you want to explore that with them=

542 **Par:** [Yeah]

543 **Int:** to see how it's affected them?

544 **Par:** Definitely, >and maybe how it's affected their family because I don't just work with
545 individuals, I work with families< so I think it's good to see how everyone makes
546 sense of that °diagnosis and has it been helpful, or actually, does it answer their
547 questions or, you know, what's the impact it's had on them and you know°, for a fair
548 few people, it's had a really negative impact=I think schizophrenia seems to, more
549 than other diagnoses comes with unfortunately, more baggage and more, kind of,
550 negative (.) things than maybe, say, depression, you know, I think it's depression is
551 'oh, that must be hard', that kind of sense around it, whereas schizophrenia, it's that

552 horrible stage of, 'oh gosh, are there going to be risky, you know, and get risk the
553 assessment out', that kind of thing, that people often check out. and often, it's totally
554 the opposite, those kind of (.) stereotypes that people are so fearful and scared of (.h)
555 everything out there that, you know, it's the total opposite so (1) yeah /erm/, I guess
556 you do something with the diagnosis to some extent, but I don't tend to use it hugely.

557 **Int:** It sounds a bit like it's, sort of, more /erm/ administrative=
558 **Par:** [Yeah]
559 **Int:** as opposed to therapeutic=
560 **Par:** [Yeah, definitely]
561 **Int:** Although it might have aspects of therapy because when you=
562 **Par:** [Yeah]
563 **Int:** ask them how it affects them=
564 **Par:** [Yeah]
565 **Int:** it gives you a sense of the person as well, then what you can work with.
566 **Par:** Definitely, yeah, >and where they're kind of coming from, I suppose, and where
567 they've come from for many years, maybe, because that's what they've been< used
568 to, you know, if they've been used to that illness thing, you can't suddenly start
569 saying, 'NO IT'S NOT AN ILLNESS', you know, you can't do that, you've kind of
570 got to go with, I suppose, where they're coming from and trying to make sense of that
571 /erm/ so yeah, I guess you can't ignore it totally and you do need to try and make
572 some sense of it, but try and work with the person into how useful is it, and I mean,
573 actually say to them, 'there are other options, you know, you don't have to stay in this
574 kind of schizophrenia kind of psychiatric system' /erm/ but that can also be quite
575 scary in itself because people have been in that way for a long time now, so the
576 thought of leaving that way can be quite difficult too.

577 **Int:** Yeah, so there's also something about (1), say for example they've been diagnosed
578 with schizophrenia [**Par:** Mmm] so in a way, this is imposed on them=
579 **Par:** [Yeah]
580 **Int:** this stigma, but at the same time, you don't want to impose an alternative way of
581 thinking=
582 **Par:** [Yeah]
583 **Int:** and say – well, it's not this=
584 **Par:** [Definitely]

585 **Int:** or something – so it's sort of finding out a balance=
 586 **Par:** [Yeah]
 587 **Int:** of how to do that as well.
 588 **Par:** >Yeah, it's kind of saying, actually let's try and see how it feels for you and how do
 589 you make sense of this which, I mean, even opening that up can be hard in itself
 590 because people haven't been given those options before to think for themselves, if you
 591 like, they're used to the doctor saying<, 'take this medication, this is what it is', kind
 592 of thing and I mean, even culturally, people don't always=or they don't have the
 593 chance to say, 'well, this is what I think it is and this is what it feels like for me', so to
 594 start saying and giving them those options can also be quite difficult for someone (1)
 595 but yeah, you don't want to impose your ideas either, I guess, is quite a balance.
 596 **Int:** And what's it like working with the families?
 597 **Par:** Oh yeah, I mean, I've really, really enjoyed it. It was quite a new thing for me, I
 598 mean, I guess I'd come across families in a home treatment kind of setting, but you
 599 don't do real formal work, if you like. we don't spend huge amounts of time, so this
 600 job was quite new for me with family work and initially=and this has got nothing to
 601 do with the diagnosis or the problem, actually, I suppose it's more around working
 602 with several people in a room, how do kind of {laughs} you juggle that and how do
 603 you work with that and different people's ideas and feelings (1) and all that sort of
 604 stuff, so that's probably got nothing really to do with the person's problems
 605 particularly /erm/ but I find it really interesting and quite /erm/ (2) in a way, it's quite
 606 liberating for a person because you're really taking away that individual problem
 607 focus, you're the problem kind of thing, you've got the illness, so you're really kind
 608 of broadening it out, thinking well actually, as a family, how can you work together,
 609 how can you get through these difficulties and the kind of stress that's within the
 610 family /erm/ and yeah, you're sort of starting from a different perspective, I think, you
 611 are moving away from that individual focus.
 612 **Int:** But do you usually see that kind of /erm/ distress within the family? I mean, is there
 613 something particular about families where people have diagnosed schizophrenia? Is
 614 that something you noticed, or maybe not?
 615 **Par:** It's hard because I haven't worked with families with other difficulties, if you like, as
 616 such but /erm/ and I think it certainly does=I don't know if it's down to the diagnosis
 617 or if it's just down to the individual=just to the person's difficulties, but I guess

618 families have often, yeah, been through all the different hospital admissions (.hh) they
619 may have seen their family member really distressed, you know, I guess having so
620 many unusual experiences that maybe they themselves haven't had, which can be
621 quite scary, you know, the family member may become, maybe a slightly different
622 person to them, you know, they can't make sense of it and maybe it's very confusing
623 for the family member, which maybe is more so with psychosis than (1) depression or
624 something, so you kind of /erm/ you know, people feeling sad and low, I guess it's
625 quite different to someone saying, I can see something in the room or I'm hearing the
626 voice of (.) whatever, you know, I guess that could be really confusing and scary for
627 the family (.h) so I suppose there's a lot to keep in mind /erm/ yeah, when working
628 with them, and thinking back about over the years, you know, if this person's in their
629 fifties or sixties and they've had these experiences for a long time, the family's gone
630 through a lot and you need to keep that in mind=but also think about actually how
631 they've survived, you know, they have survived and now they've kind of got through
632 it /erm/ yeah.

633 **Int:** So resilience in a way?

634 **Par:** Huge resilience, I think even when I work with individuals, yeah, you do think about
635 the resilience, you know, people seem to be very resilient and you sometimes worry
636 so much about them, thinking, 'gosh, are they going to be ok', but actually, you know,
637 they've come this far {laughs} on their own, you know, you think, yeah, we have to
638 respect that resilience they have, definitely, yeah.

639 **Int:** OK, so are there, sort of, any issues about diagnosis that we've missed, or that you'd
640 like to bring up, or what you think like that?

641 **Par:** I don't think so, I just think particularly within this role and this job, it's really
642 developed me as therapist and as a practitioner=I think it's really allowed me to see
643 that actually=yeah, I mean, I guess as >counselling psychologists<, we're not, we're
644 not particularly, what's the word (1) lovers of diagnosis and stuff {laughs}, I guess
645 we really do want to get to know a person, so I think we are quite well equipped really
646 to do that and I guess with this client group, so it does feel possible to put it to one
647 side and start getting to know the person and understanding them, and those kind of
648 things, so I think, yeah, I think it's nice now that we are able to broaden our /erm/
649 areas of work, I guess, yeah.

650 **Int:** It sounds also like that it, sort of, you need some experience and patience in order to
651 do that, and=
652 **Par:** [Yea:h]
653 **Int:** also a bit of daring to sort of, overcome all these ideas you have about the
654 schizophrenia=
655 **Par:** [Yeah]
656 **Int:** and throw yourself in there and learn the work.
657 **Par:** Yeah, I think you really need a lot of support from a supervisor and I think that's
658 really enabled me to do that these last couple of years /erm/ maybe not in my first
659 year, I wouldn't have felt able to do this /erm/ because I think yeah, maybe you want
660 to feel a bit more comfortable with (1) /erm/ I guess your kind of therapeutic models
661 and those kind of things, maybe you'd want to feel you've got a bit of grounding there
662 (.h) /erm/ because if you're feeling maybe a bit less confident about them, I guess you
663 have a lot to juggle, you know, you kind of have an awful lot to think about, so /erm/
664 yeah, I think maybe later on in your training but /erm/ yeah, I really don't see why
665 there's not a reason to try these things, yeah.
666 **Int:** That's great, thank you!
667 **Par:** Thank you {laughs}.

References

- Abell, J. & Stokoe, E. H. (1999). 'I take full responsibility, I take some responsibility, I'll take half of it but no more than that': Princess Diana and the negotiation of blame in the 'Panorama' interview. *Discourse Studies*, 1(3), 297-319.
- Adityanjee, Aderibigbe, Y.A., Theodoridis, D. & Vieweg, W.V.R. (1999). Dementia praecox to schizophrenia: The first 100 years. *Psychiatry and Clinical Neurosciences*, 53(4), 437-448.
- Albee, G.W. (2000). The Boulder model's fatal flaw. *American Psychologist*, 55(2), 247-248.
- Alvesson, M. & Sköldberg, K. (2000). *Reflexive Methodology: New Vistas for Qualitative Research*. London: Sage Publications.
- Alvesson, M. & Sköldberg, K. (2009). *Reflexive Methodology: New Vistas for Qualitative Research (Second Edition)*. London: Sage Publications.
- American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition)*. Washington, D.C.: APA.
- American Psychiatric Association (2004). *Practice Guideline for the Treatment of Patients with Schizophrenia (Second Edition)*. Washington DC: APA.
- Andreasen, N.C. (1997). The evolving concept of schizophrenia: From Kraepelin to the present and future. *Schizophrenia Research*, 28(2), 105-109.
- Andreasen, N.C. (2007). DSM and the death of phenomenology in America: An example of unintended consequences. *Schizophrenia Bulletin*, 33(1), 108-112.
- Angen, M.J. (2000). Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. *Qualitative Health Research*, 10(3), 378-395.
- Angermeyer, M. & Matschinger, H. (1996). The effect of diagnostic labelling on the lay theory regarding schizophrenic disorders. *Social Psychiatry and Psychiatric Epidemiology*, 31(6), 316-320.
- Antaki, C. & Wetherell, M. (1999). Show concessions. *Discourse Studies*, 1(1), 7-27.
- Antaki, C., Billig, M., Edwards, D. & Potter, J. (2003). Discourse analysis means doing analysis: A critique of six analytic shortcomings. *Discourse Analysis Online*, 1(1), Available at: <http://www.shu.ac.uk/daol/articles/v1/n1/a1/antaki2002002-paper.html> (accessed 06 February 2010).
- Anthony, W.A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11-23.
- Arribas-Ayllon, M. & Walkerdine, V. (2008). Foucauldian discourse analysis. In: C. Willig & W. Stainton Rogers (Eds.), *The Sage Handbook of Qualitative Research in Psychology*, pp.91-108. London: Sage Publications.

Atkinson, E. (2000). Behind the Inquiring Mind: Exploring the transition from external to internal inquiry. *Reflective Practice*, 1(2), 149-164.

Atkinson, J.M. & Heritage, J.C. (Eds.) (1984). *Structures of Social Action: Studies in Conversation Analysis*. Cambridge: Cambridge University Press.

Avdi, E. & Georgaca, E. (2007). Discourse analysis and psychotherapy: A critical review. *European Journal of Psychotherapy and Counselling*, 9(2), 157-176.

Banton, R., Clifford, P., Frosh, S., Lousada, J. & Rosenthal, J. (1985). *The Politics of Mental Health*. London: Macmillan.

Barkham, M. (1990). Counselling psychology: In search of an identity. *The Psychologist*, 12, 536-539.

Barriball, K.L. & While, A. (1994). Collecting data using a semi-structured interview: A discussion paper. *Journal of Advanced Nursing*, 19(2), 328-335.

Barritt, L.S., Beekman, T., Bleeker, H., Mulderij, K. (1983). The world through children's eyes: Hide and seek and peekaboo. *Phenomenology + Pedagogy*, 1(2), 140-161.

Barry, M.M. & Greene, S.M. (1992). Implicit models of mental disorders: A qualitative approach to the delineation of attitudes. *Irish Journal of Psychology*, 13, 141-160.

Bentall, R.P., Jackson, H. & Pilgrim, D. (1988). Abandoning the concept of 'schizophrenia': Some implications of validity arguments for psychological research into psychotic phenomena. *British Journal of Clinical Psychology*, 27(4), 303-324.

Bentall, R.P. (2004). *Madness Explained: Psychosis and Human Nature*. London: Penguin.

Bentall, R.P., Lewis, S., Tarrier, G., Haddock Drake, R. & Day, J. (2003). Relationships matter: The impact of the therapeutic alliance on outcome in schizophrenia. *International Congress on Schizophrenia Research*, 20, 319.

Berrios, G.E. (1991). Delusions as "wrong beliefs": A conceptual history. *British Journal of Psychiatry*, 159, Supplement 14, 6-13.

Bhaskar, R. (1975). *A Realist Theory of Science*. Leeds: Leeds Books.

Bhaskar, R. (1978). *A Realist Theory of Science (Second Edition)*. Brighton: Harvester Press.

Bhaskar, R. (1986). *Scientific Realism and Human Emancipation*. London: Verso.

Bhaskar, R. (1989). *Reclaiming Reality: A Critical Introduction to Contemporary Philosophy*. London: Verso.

Billig, M. (1987). *Arguing and Thinking: A Rhetorical Approach to Social Psychology*. Cambridge: Cambridge University Press.

- Billig, M., Condor, S., Edwards, D., Gane, M., Middleton, D. & Radley, A. (1988). *Ideological Dilemmas: A Social Psychology of Everyday Thinking*. London: Sage Publications.
- Blaikie, N. (2000). *Designing Social Research: The Logic of Anticipation*. Cambridge: Polity Press.
- Blommaert, J. (1997). Whose background? Comments on a discourse analytic-reconstruction of the Warsaw uprising. *Pragmatics*, 7(1), 69-81.
- Bond, T. (2007). *Standards and Ethics for Counselling in Action (Second Edition)*. London: Sage Publications.
- Bor, R. & du Plessis, P. (1997). Counselling psychology research in health care settings. *Counselling Psychology Review*, 12, 19-22.
- Boyle, M. (1994). Schizophrenia and the art of the soluble. *The Psychologist*, 7, 399-404.
- Boyle, M. (1999). Diagnosis. In: C. Newnes, G. Holmes. & C. Dunn (Eds.), *This is Madness: A Critical Look at Psychiatry and the Future of Mental Health Services*, pp.75-90. Ross-on-Wye: PCCS Books.
- Boyle, M. (2002). *Schizophrenia: A Scientific Delusion?* London: Routledge.
- Boyle, M. (2005). *Schizophrenia: A Scientific Delusion? (Second Edition)*. London: Routledge.
- Boyle, M. (2007). The problem with diagnosis. *The Psychologist*, 20(5), 290-292.
- Bracken, P. & Thomas, P. (2001). Postpsychiatry: A new direction for mental health. *British Medical Journal*, 322(7288), 724-727.
- Brennan, J. & Hollanders, H. (2004). Trouble in the village? Counselling and clinical psychology in the NHS. *Psychotherapy and Politics International*, 2(2), 124-134.
- Breuer, F. (2000). Qualitative methods in the study of biographies, interactions and everyday life contexts: The development of a research style. *Forum: Qualitative Social Research*, 1(2), Available at: <http://www.qualitative-research.net/index.php/fqs/article/view/1072/2330> (accessed 07 February 2010).
- Brinkmann, S. & Kvale, S. (2008). Ethics in qualitative psychological research. In: C. Willig & W. Stainton Rogers (Eds.), *The Sage Handbook of Qualitative Research*, pp.263-279. London: Sage Publications.
- British Psychological Society (2000). *Recent Advances in Understanding Mental Illness and Psychotic Experiences: A Report by the British Psychological Society Division of Clinical Psychology*. Leicester: British Psychological Society.

British Psychological Society (2002). *Division of Counselling Psychology: Guidelines on Confidentiality and Record Keeping*. Leicester: British Psychological Society.

British Psychological Society (2006a). *Code of Ethics and Conduct*. Leicester: British Psychological Society.

British Psychological Society (2006b). *Division of Counselling Psychology: Professional Practice Guidelines*. Leicester: British Psychological Society.

Brown, C. (2005). *Postmodernism for Historians*. Harlow: Pearson Longman.

Brown, J.F. (2002). Epistemological differences within psychological science: A philosophical perspective on the validity of psychiatric diagnoses. *Psychology and Psychotherapy: Theory, Research and Practice*, 75(3), 239-250.

Brown, P. (1995). Naming and framing: The social construction of diagnosis. *Journal of Health and Social Behavior*, 35(extra issue), 35-52.

Brown, J. & Corne, L. (2004). Counselling psychology in Australia. *Counselling Psychology Quarterly*, 17(3), 287-299.

Bucholtz, M. (2000). The politics of transcription. *Journal of Pragmatics*, 32(10), 1439-1465.

Burkitt, I. (1999). Between the dark and the light: Power and the material contexts of social relations. In: D.J. Nightingale & J. Cromby (Eds.), *Social Constructionist Psychology: A Critical Analysis of Theory and Practice*, pp.69-82. Buckingham: Open University Press.

Burman, E. (1991). What discourse is not. *Philosophical Psychology*, 4(3), 325-342.

Burman, E. (1996). Introduction: Contexts, contests and interventions. In: E. Burman, P. Aldrede, C. Bewley & B. Goldberg (Eds.), *Challenging Women: Psychology's Exclusions, Feminist Possibilities*, pp.1-19. Buckingham: Open University Press.

Burman, E. (2004). Discourse analysis means analysing discourse: Some comments on Antaki, Billig, Edwards and Potter 'Discourse analysis means doing analysis: A critique of six analytic shortcomings'. *Discourse Analysis Online*, Available at: <http://extra.shu.ac.uk/daol/articles/open/2003/003/burman2003003-paper.html> (accessed 06 February 2010).

Burman, E. & Parker, I. (Eds.) (1993). *Discourse Analytic Research: Repertoires and Readings of Texts in Action*. London: Routledge.

Burr, V. (1995). *An Introduction to Social Constructionism*. London: Routledge.

Burr, V. (2003). *Social Constructionism (Second Edition)*. London: Routledge.

Bury, D. & Strauss, S.M. (2006). The scientist practitioner in a counselling psychology setting. In: D.A. Lane & S. Corrie (Authors), *The Modern Scientist-Practitioner: A Guide to Practice in Psychology*, pp.119-129. Hove, East Sussex: Routledge.

Campbell, P. (1996). The history of the user movement in the United Kingdom. In: T. Heller (Ed.), *Mental Health Matters: A Reader*, pp.218-225. Basingstoke: MacMillan.

Campbell, P. (2002) Doing it for ourselves. *Mental Health Today*, October, 28-30.

Campbell, P. (2007). Hearing my voice. *The Psychologist*, 20(5), 298-299.

Care Services Improvement Partnership (2007). *Commissioning a Brighter Future: Improving Access to Psychological Therapies*. London: CSIP.

Carpenter, W.T. (1986). Thoughts on the treatment of schizophrenia. *Schizophrenia Bulletin*, 12(4), 527-538.

Carter, J.A. (2002). Integrating science and practice: Reclaiming the science in practice. *Journal of Clinical Psychology*, 58(10), 1285-1290.

Carter, S.M. & Little, M. (2007). Justifying knowledge, justifying method, taking action: Epistemologies, methodologies and methods in qualitative research. *Qualitative Health Research*, 17(10), 1316-1328.

Chadwick, P.K. (2007). *Schizophrenia: The Positive Perspective*. London: Routledge.

Charmaz, C. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Research*. London: Sage Publications.

Cheek, J. (1997). Negotiating delicately: Conversations about health. *Health and Social Care in the Community*, 5(1), 23-27.

Cheek, J. (2004). At the margins? Discourse analysis in qualitative research. *Qualitative Health Research*, 14(8), 1140-1150.

Chwalisz, K. (2003). Evidence-based practice: A framework for twentieth-first-century scientist-practitioner training. *The Counseling Psychologist*, 31(5), 497-528.

Clark, D. & Turpin, G. (2008). Improving opportunities. *The Psychologist*, 21(8), 700-701.

Cohen, C.I. (1993). The biomedicalization of psychiatry: A critical overview. *Community Mental Health Journal*, 29(6), 508-521.

Coleman, M. & Jenkins, E. (1998). Developments in mental health nursing: A critical voice. *Journal of Psychiatric and Mental Health Nursing*, 5(5), 355-359.

Colman, A.M. (2006). *Oxford Dictionary of Psychology*. Oxford: Oxford University Press.

Cooper, M. (2009). Welcoming the Other: Actualising the humanistic ethic at the core of counselling psychology practice. *Counselling Psychology Review*, 24(3&4), 119-129.

Cooper, R. (2004). What is wrong with the DSM? *History of Psychiatry*, 15(1), 5-25.

Corrie, S. & Callahan, M.M. (2000). A review of the scientist-practitioner model: Reflections on its potential contribution to counselling psychology within the context of current health care trends. *British Journal of Medical Psychology*, 73(3), 413-427.

Cosgrove, L. & McHugh, M. (2008). A post-Newtonian, postmodern approach to science: New methods in social action research. In: S.N. Hesse-Bibber & P. Leavy (Eds.), *Handbook of Emergent Methods*, pp.73-86. London: Guildford Press.

Cosgrove, L. (2005). When labels mask oppression: Implications for teaching psychiatric taxonomy to mental health counselors. *Journal of Mental Health Counseling*, 27(4), 283-296.

Coursey, R.D., Keller, A.B., Farrell, W.B. (1995). Individual psychotherapy and persons with serious mental illness: The client's perspective. *Schizophrenia Bulletin*, 21(2), 283-301.

Coyle, A. (2006). Discourse analysis. In: G.M. Breakwell, C. Fife-Schaw, S.Hammond & J.A. Smith (Eds.), *Research Methods in Psychology (Third Edition)*, pp.366-387. London: Sage Publications.

Coyle, A. (2007). Discourse analysis. In: E. Lyons & A. Coyle (Eds.), *Analysing Qualitative Data in Psychology*, pp.98-116. London: Sage Publications.

Craven, M. & Coyle, A. (2007). Counselling psychologists' talk about 'psychopathology' and diagnostic categories: A reflective account of a discourse analytic study. In: E. Lyons & A. Coyle (Eds.), *Analysing Qualitative Data in Psychology*, pp.235-247. London: Sage Publications.

Cromby, J., Harper, D. & Reavey, P. (2007). Moving beyond diagnosis: Practising what we preach. *The Psychologist*, 20(5), 289.

Crowe, M. (2000). Constructing normality: A discourse analysis of the DSM-IV. *Journal of Psychiatric and Mental Health Nursing*, 7(1), 69-77.

Davies, B. (1998). Psychology's subject: A commentary on the relativism/realism debate. In: I. Parker (Ed.), *Social Constructionism, Discourse and Realism*, pp.133-146. London: Sage Publications.

Davies, B. & Harré, R. (1990). Positioning: The discursive production of selves. *Journal for the Theory of Social Behaviour*, 20(1), 43-63.

Deegan, P. (1988). Recovery: The lived experience of rehabilitation. *Psychiatric Rehabilitation Journal*, 11(4), 11-19.

Deegan, P. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, 19(3), 91-98.

Denzin, N.K. & Lincoln, Y.S. (Eds.). (2000). *Handbook of Qualitative Research (Second Edition)*. London: Sage Publications.

- Department of Health (1983). *Mental Health Act 1983*. London: Department of Health.
- Department of Health (2007). *New Ways of Working for Applied Psychologists in Health and Social Care: Models of Training*. Leicester: British Psychological Society.
- Derrida, J. (1976). *Of Grammatology*. Baltimore: Johns Hopkins Press.
- Derrida, J. (1990). *Writing and Difference* (Trans. A. Bass). London: Routledge.
- van Deurzen-Smith, E. (1990). Philosophical underpinnings of counselling psychology. *Counselling Psychology Review*, 5(2), 8-12.
- Dickerson, F.B., Sommerville, J., Origoni, A.E., Ringel, N.B. & Parente, F. (2002). Experiences of stigma among outpatients with schizophrenia. *Schizophrenia Bulletin*, 28(1), 143-155.
- van Dijk, T. (1997). Analysing discourse analysis. *Discourse and Society*, 8(1), 5-6.
- Dingman, C.W. & McGlashan (1989). Psychotherapy. In: A.S. Bellack (Ed.), *A Clinical Guide for the Treatment of Schizophrenia*, pp.263-282. New York: Plenum Press.
- Double, D.B. (1990). What would Adolf Meyer have thought of the neo-Kraepelinian approach? *Psychiatric Bulletin*, 14, 472-474.
- Dougher, M. J. (1995). A bigger picture: Cause and cognition in relation to differing scientific frameworks. *Journal of Behavior Therapy and Experimental Psychiatry*, 26(3), 215-219.
- Douglas, B. (2010). Disorder and its discontents. In: R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden (Eds.), *Handbook of Counselling Psychology (Third Edition)*, pp.23-43. London: Sage Publications.
- Dryden, W., Mearns, D. & Thorne, B. (2000). Counselling in the United Kingdom: Past, present and future. *British Journal of Guidance and Counselling*, 28(4), 467-483.
- East, P. (1995). *Counselling in Medical Settings*. Buckingham: Open University Press.
- Edley, N. (2001). Unravelling social constructionism. *Theory and Psychology*, 11(3), 433-441.
- Edley, N. (2008). Analysing masculinity: Interpretative repertoires, ideological dilemmas and subject positions. In: M. Wetherell, S. Taylor, & S.J. Yates (Eds.), *Discourse as Data: A Guide for Analysis*, pp.189-228. London: Sage Publications.
- Edley, N. & Wetherell, M. (1999). Imagined futures: Young men's talk about fatherhood and domestic life. *British Journal of Social Psychology*, 38(2), 181-194.
- Edley, N. & Wetherell, M. (2001). Jekyll and Hyde: Men's constructions of feminism and feminists. *Feminism and Psychology*, 11(4), 439-457.

- Edwards, D. (1999). Emotion discourse. *Culture and Psychology*, 5(3), 271-291.
- Edwards, D., Ashmore, M. & Potter, P. (1995). Death and furniture: The rhetoric, politics and theology of bottom line arguments against relativism. *History of the Human Sciences*, 8(2), 25-49.
- Edwards, D. & Potter, J. (1992). *Discursive Psychology*. London: Sage Publications.
- Edwards, D. & Potter, J. (1993). Language and causation: A discursive action model of description and attribution. *Psychological Review*, 100(3), 23-41.
- Eilan, N. (2000). On understanding schizophrenia. In: D. Zahavi (Ed.), *Exploring the Self: Philosophical and Psychopathological Perspectives on Self-Experience*, pp.97-114. Philadelphia: John Benjamins Publishing Company.
- Elliott, R., Fischer, C.T. & Rennie, D. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.
- Eriksen, K. & Kress, V.E. (2006). The DSM and the professional counseling identity: Bridging the gap. *Journal of Mental Health Counseling*, 28(3), 202-217.
- Estroff, S.E. (1989). Self, identity, and subjective experiences of schizophrenia: In search of the subject. *Schizophrenia Bulletin*, 15(2), 189-196.
- Fairclough, N., Jessop, B. & Sayer, A. (2004). Critical realism and semiosis. In: J. Joseph & J.M. Roberts (Eds.), *Realism Discourse and Deconstruction*, pp.23-42. London: Routledge.
- Fenton, W.S. (2000). Evolving perspectives on individual psychotherapy for schizophrenia. *Schizophrenia Bulletin*, 26(1), 47-72.
- Finlay, L. (1998). Reflexivity: An essential component for all research? *British Journal of Occupational Therapy*, 61(10), 453-456.
- Finlay, L. (2002a). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research*, 12(4), 531-545.
- Finlay, L. (2002b). Negotiating the swamp: The opportunity and challenge of reflexivity in research practice. *Qualitative Research*, 2(2), 209-230.
- Finlay, L. (2003). The reflexive journey: Mapping multiple routes. In: L. Finlay & B. Gough (Eds.), *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences*, pp.3-30. Oxford: Blackwell.
- Foucault, M. (1972). *The Archaeology of Knowledge*. London: Tavistock.
- Foucault, M. (1976). *Madness and Civilization*. London: Tavistock.

- Foucault, M. (1980). *Power/Knowledge: Selected Interview and Other Writings*. New York: Pantheon.
- Foucault, M. (1982). Afterword: The subject and power. In: H. L. Dreyfus & P. Rabinow (Eds.), *Michel Foucault: Beyond Structuralism and Hermeneutics*, pp.208-228. New York: Harvester Press.
- Foucault, M. (2002). *The Order of Things: An Archaeology of the Human Sciences*. Abingdon: Routledge Classics.
- Fox, D. & Prilleltensky, I. (Eds.) (1997). *Critical Psychology: An Introduction*. London: Sage Publications.
- Fox, D., Prilleltensky, I. & Austin, S. (Eds.) (2009). *Critical Psychology: An Introduction (Second Edition)*. London: Sage Publications.
- Frank, A.F. & Gunderson, J.G. (1990). The role of the therapeutic alliance in the treatment of schizophrenia: Relationship to course and outcome. *Archives of General Psychiatry*, 47(3), 228-236.
- Frese, F.J., Stanley, J., Ken Kress, J.D. & Vogel-Scibilia, S. (2001). Integrating evidence-based practices and the recovery model. *Psychiatric Services*, 52(11), 1462-1468.
- Fretz, B.R. (1980). Counseling psychology: 2001. *The Counseling Psychologist*, 8(4), 8-11.
- Frith, C.D. (1992). *The Cognitive Neuropsychology of Schizophrenia*. Hillsdale, NJ: Lawrence Erlbaum Associates.
- Furnham, A. & Bower, P. (1992). A comparison of academic and lay theories of schizophrenia. *British Journal of Psychiatry*, 161, 201-210.
- Gallagher, A.G., Gemez, T. & Baker, L.J.V. (1991). Beliefs of psychologists about schizophrenia and their role in its treatment. *The Irish Journal of Psychology*, 12(4), 393-405.
- Garret, M., Stone, D. & Turkington, D. (2006). Normalizing psychotic symptoms. *Psychology and Psychotherapy: Theory, Research and Practice*, 79(4), 595-610.
- Geekie, J. & Read, J. (2009). *Making Sense of Madness: Contesting the Meaning of Schizophrenia*. Hove, East Sussex: Routledge.
- Geekie, J. (2004). Listening to the voices we hear: Clients' understandings of psychotic experiences. In: J. Read, L.R. Moshier & R.P. Bentall (Eds.), *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia*, pp.147-160. Hove, East Sussex: Routledge.
- Georgaca, E. (2000). Reality and discourse: A critical analysis of the category of 'delusions'. *British Journal of Medical Psychology*, 73(2), 227-242.

- Gergen, K.J. (1985). The social constructionist movement in modern psychology. *American Psychologist*, 40(33), 266-275.
- Gergen, K.J. (1989). Social psychology and the wrong revolution. *European Journal of Social Psychology*, 19(5), 463-484.
- Gergen, K.J. (1997). *Realities and Relationships: Soundings in Social Construction*. Cambridge, MA: Harvard University Press.
- Gergen, K.J. (1999). *An Invitation to Social Construction*. London: Sage Publications.
- Gergen, K.J. (2001a). Construction in contention: Towards consequential resolutions. *Theory and Psychology*, 11(3), 419-432.
- Gergen, K.J. (2001b). Psychological science in a postmodern context. *American Psychologist*, 56(10), 803-813.
- Gergen, K.J. & Gergen, M.M. (1991). Towards reflexive methodologies. In: F. Steier (Ed.), *Research and Reflexivity*, pp.77-95. London: Sage Publications.
- Giddens, A. (1984). *The Constitution of Society: Outline of the Theory of Structuration*. Cambridge: Polity Press.
- Gilbert, G.N. & Mulkay, M. (1984). *Opening Pandora's Box: A Sociological Analysis of Scientists' Discourse*. Cambridge: Cambridge University Press.
- Gill, R. (1995). Relativism, reflexivity and politics: Interrogating discourse analysis from a feminist perspective. In: S. Wilkinson & C. Kitzinger (Eds.), *Feminism and Discourse: Psychological Perspectives*, pp.165-186. London: Sage Publications.
- Gillies, F. (2010). Being with humans: An evolutionary framework for the therapeutic relationship. In: M. Milton (Ed.), *Therapy and Beyond: Counselling Psychology Contributions to Therapeutic and Social Issues*, pp.73-88. Chichester: Wiley-Blackwell.
- Glaser, B.G. & Strauss, A.L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine.
- Glazer, W. M. & Ereshefsky, L. (1996). A pharmacoeconomic model of outpatient antipsychotic therapy in 'revolving door' schizophrenic patients. *Journal of Clinical Psychiatry*, 57(8), 337-345.
- Goffman, E. (1981). Footing. In: E. Goffman (Ed.), *Forms of Talk*, pp.124-159. Philadelphia: Philadelphia University Press.
- Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report*, 8(4), 597-604.

- Goldfried, M.R. & Eubanks-Carter, C. (2004). On the need for a new psychotherapy research paradigm: Comment on Westen, Novotny, and Thompson-Brenner (2004). *Psychological Bulletin*, 130(4), 669-673.
- Golsworthy, R. (2004). Counselling psychology and psychiatric classification: Clash or co-existence? *Counselling Psychology Review*, 19(3), 23-28.
- Gough, B. (2003). Deconstructing reflexivity. In: L. Finlay & B. Gough (Eds.), *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences*, pp.21-36. Oxford: Blackwell.
- Grob, G. (1998). Psychiatry's Holy Grail: The search for the mechanisms of mental disease. *Bulletin of the History of Medicine*, 72(2), 189-219.
- Guilfoyle, M. (2002). Power, knowledge and resistance in therapy: Exploring links between discourse and materiality. *International Journal of Psychotherapy*, 7(1), 83-97.
- Guillemin, M. & Gillam, L. (2004). Ethics, reflexivity, and "ethically important moments" in research. *Qualitative Inquiry*, 10(2), 261-280.
- Guimón, J. (2004). *Relational Mental Health: Beyond Evidence-Based Interventions*. New York: Plenum Publishers.
- Hage, S.M. (2002). Reaffirming the unique identity of counseling psychology: Opting for the "Road Less Travelled By". *The Counseling Psychologist*, 31(5), 555-563.
- Haghighat, R. (2008). Schizophrenia as social discourse: How do people use their diagnosis for social action? *European Psychiatry*, 23(8), 549-560.
- Hansen, J.T. (2004). Thoughts on knowing: Epistemic implications of counseling practice. *Journal of Counseling and Development*, 82(2), 131-138.
- Hansen, J.T. (2005a). The devaluation of inner subjective experiences by the counseling profession: A plea to reclaim the essence of the profession. *Journal of Counseling and Development*, 83(3), 406-415.
- Hansen, J.T. (2005b). Truth or consequences: A neopragmatic critique of contemporary mental health culture. *Journal of Mental Health Counseling*, 27(3), 210-220.
- Hansen, J.T. (2006). Counseling theories within a postmodern epistemology: New roles for theories in counseling practice. *Journal of Counseling and Development*, 84(3), 291-297.
- Hare-Mustin, R.T. & Marecek, J. (1997). Abnormal and clinical psychology: The politics of madness. In: D. Fox & I. Prilleltensky (Eds.), *Critical Psychology: An Introduction*, pp.104-120. London: Sage Publications.
- Harper, D.J. (1994). The professional construction of 'paranoia' and the discursive use of diagnostic criteria. *British Journal of Medical Psychology*, 67(2), 131-143.

- Harper, D.J. (1995). Discourse analysis and 'mental health'. *Journal of Mental Health*, 4(4), 347-358.
- Harper, D.J. (1999). *Deconstructing Paranoia: An Analysis of the Discourses Associated with the Concept of Paranoid Delusion*. Unpublished PhD thesis, University of East London.
- Harper, D.J. (2003). Developing a critically reflexive position using discourse analysis. In: L. Finlay & B. Gough (Eds.), *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences*, pp.78-92. Oxford: Blackwell.
- Harper, D.J. (2004). Delusions and discourse: Moving beyond the modernist paradigm. *Philosophy, Psychiatry and Psychology*, 11(1), 55-64.
- Harper, D.J., O'Connor, J., Self, P. & Stevens, P. (2008). Learning to use discourse analysis on a professional psychology training programme: Accounts of supervisees and a supervisor. *Qualitative Research in Psychology*, 5(3), 192-213.
- Harré, R., Moghaddam, F.M., Pilkerton Cairnie, T., Rothbart, D. & Sabat, S.R. (2009). Recent advances in positioning theory. *Theory and Psychology*, 19(1), 5-31.
- Harris, B. (2009). What critical psychologists should now about the history of psychology. In: D. Fox, I. Prilleltensky & S. Austin (Eds.), *Critical Psychology: An Introduction (Second Edition)*, pp.20-35. London: Sage Publications.
- Hart, N. (2003). The power of language in therapeutic relationship. In: Y. Bates & R. House (Eds.), *Ethically Challenged Professions: Enabling Innovation and Diversity in Psychotherapy and Counselling*, pp.218-225. Ross-on-Wye: PCCS Books.
- Haverkamp, B.E. (2005). Ethical perspectives on qualitative research in applied psychology. *Journal of Counseling Psychology*, 52(2), 146-155.
- Haverkamp, B.E. & Young, R.A. (2007). Paradigms, purpose, and the role of the literature: Formulating a rationale for qualitative investigations. *The Counseling Psychologist*, 35(2), 265-294.
- Heinrichs, W. (1993). Schizophrenia: A cognitive model and its implications for psychological intervention. *Behavior Modification*, 20(2), 115-124.
- Henwood, K.L. & Pidgeon, N.F. (1992). Qualitative research and psychological theorizing. *British Journal of Psychology*, 83(1), 97-111.
- Hepburn, A. (1999). Derrida and psychology: Deconstruction and its ab/uses in critical and discursive psychologies. *Theory and Psychology*, 9(5), 639-665.
- Heracleous, L. & Hendry, J. (2000). Discourse and the study of organization: Toward a structurational perspective. *Human Relations*, 53(10), 1251-1286.
- Heritage, J. (2002). The limits of questioning: Negative interrogatives and hostile question content. *Journal of Pragmatics*, 34(10-11), 1427-1446.

- Heshusius, L. (1994). Freeing ourselves from objectivity: Managing subjectivity or turning toward a participatory mode of consciousness? *Educational Researcher*, 23(3), 15-22.
- Hewitt, J. & Coffey, M. (2005). Therapeutic working relationships with people with schizophrenia: Literature review. *Journal of Advanced Nursing*, 52(5), 561-570.
- Hewitt, J.P. & Stokes, R. (1975). Disclaimers. *American Sociological Review*, 40(1), 1-11.
- Hook, D. (2001). Discourse, knowledge, materiality, history: Foucault and discourse analysis. *Theory and Psychology*, 11(4), 521-547.
- Hook, D. & Parker, I. (2002). Deconstruction, psychopathology and dialectics. *South African Journal of Psychology*, 32(2), 49-54.
- Horrobin, D. (2002). *The Madness of Adam and Eve: How Schizophrenia Shaped Humanity*. London: Corgi.
- Howard, C. & Tuffin, K. (2002). Repression in retrospect: Constructing history in the 'memory debate'. *History of the Human Sciences*, 15(3), 75-93.
- Howgego, I.M., Yellowlees, P., Owen, C., Meldrum, L. & Dark, F. (2003). The therapeutic alliance: The key to effective patient outcome? A descriptive review of the evidence in community mental health case management. *Australian and New Zealand Journal of Psychiatry*, 37, 169-183.
- Howkins, E.J. & Ewens, A. (1999). How students experience professional socialisation. *International Journal of Nursing Studies*, 35, 41-49.
- Jacobs, M. (2000). Psychotherapy in the United Kingdom: Past, present and future. *British Journal of Guidance and Counselling*, 28(4), 451-466.
- James, P.E. & Bellamy, A. (2010). Counselling psychology in the NHS. In: R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden (Eds.). *Handbook of Counselling Psychology (Third Edition)*, pp.397-415. London: Sage Publications.
- Jaspers, K. (1963). *General Psychopathology (Seventh Edition)* (Trans. J. Hoenig & M.W. Hamilton). Manchester: Manchester University Press.
- Jefferson, G. (1990). List-construction as a task and resource. In: G. Psathas (Ed.), *Interaction Competence*, pp.63-92. Lanham, MD: University Press of America.
- Jenkins, J.H. & Barrett, R.J. (Eds.) (2003). *Schizophrenia, Culture and Subjectivity: The Edge of Experience*. Cambridge: Cambridge University Press.
- Jensen, D.R. (2006). *Medical Model Influence in Counseling and Psychotherapy: Counseling Psychology Training Directors' Views*. Unpublished PhD thesis, Brigham Young University.

- Johansson, H. & Eklund, M. (2003). Patients' opinion on what constitutes good psychiatric care. *Scandinavian Journal of Caring Sciences*, 17(4), 339-346.
- Jorm, A., Christensen, H. & Griffiths, K. (2005). Public beliefs about causes and risk factors for mental disorders. *Social Psychiatry and Psychiatric Epidemiology*, 40(9), 764-767.
- Joseph, J. & Roberts, J.M. (2004). Introduction: Realism, discourse and deconstruction. In: J. Joseph & J.M. Roberts (Eds.), *Realism Discourse and Deconstruction*, pp.1-19. London: Routledge.
- Jost, J.T. & Hardin, C.D. (1996). The practical turn in psychology: Marx and Wittgenstein as social materialists. *Theory and Psychology*, 6(3), 385-393.
- Kanellakis, P. (Ed.) (2003). Counselling psychology and psychological testing. *Counselling Psychology Review*, 19(4), 4-44.
- Karon, B.P. (1999). The tragedy of schizophrenia. *The General Psychologist*, 32(1), 1-12.
- Kaczmarek, P. (2006). Counseling psychology and strength-based counseling: A promise yet to fully materialize. *The Counseling Psychologist*, 34(1), 13-79.
- Keen, E. (1997). Psychiatric power and levels of concealment. *Journal of Constructivist Psychology*, 10(2), 125-137.
- Kendall, G. & Wickham, G. (1999). *Using Foucault's Methods*. London: Sage Publications.
- Kenwood, C. (1999). Social constructionism: Implications for psychotherapeutic practice. In: D.J. Nightingale & J. Cromby (Eds.), *Social Constructionist Psychology: A Critical Analysis of Theory and Practice*, pp.176-189. Buckingham: Open University Press.
- Kidder, L.H. & Fine, M. (1997). Qualitative inquiry in psychology: A radical tradition. In: D. Fox, & I. Prilleltensky (Eds.), *Critical Psychology: An Introduction*, pp.51-67. London: Sage Publications.
- Kinderman, P. (2009). The future of Counselling Psychology: A view from the outside. *Counselling Psychology Review*, 24(1), 16-21.
- Knight, T. (2005). You'd better believe it: Accepting and working within the client's own reality. *Clinical Psychology Forum*, 155, 38-42.
- Knudson, B. & Coyle, A. (1999). Coping strategies for auditory hallucinations: A review. *Counselling Psychology Quarterly*, 12(1), 25-38.
- Kvale, S. (1996). *InterViews: An Introduction to Qualitative Research Interviewing*. London: Sage Publications.
- Laing, R.D. (1990a). *The Divided Self: An Existential Study in Sanity and Madness*. London: Penguin Books.

- Laing, R.D. (1990b). *The Politics of Experience and The Bird of Paradise*. London: Penguin Books.
- Lalande, V.M. (2004). Counselling psychology: A Canadian perspective. *Counselling Psychology Quarterly*, 17(3), 273-286.
- Lambert, G. & Gournay, K. (1999). Training for the mental health workforce: A review of developments in the United Kingdom. *Australian and New Zealand Journal of Psychiatry*, 33(5), 694-700.
- Lane, D.A. & Corrie, S. (2006). Counselling Psychology: Its influences and future. *Counselling Psychology Review*, 21(1), 12-24.
- Larkin, W. & Morrison, A.P. (Eds.) (2006). *Trauma and Psychosis: New Directions for Theory and Therapy*. London: Routledge.
- Laungani, P. (2002). Mindless psychiatry and dubious ethics. *Counselling Psychology Quarterly*, 15(1), 23-33.
- Laurence, J. (2003). *Pure Madness: How Fear Drives the Mental Health System*. London: Routledge.
- Layard, R. (2006). The case for psychological treatment centres. *British Medical Journal*, 332(7548), 1030-1032.
- Leach, M.M., Akhurst, J. & Basson, C. (2003). Counseling psychology in South Africa: Current political and professional challenges and future promise. *The Counseling Psychologist*, 31(5) 619-640.
- Levey, S. & Howells, K. (1994). Accounting for the fear of schizophrenia. *Journal of Community and Applied Social Psychology*, 4(5), 313-328.
- Levinas, E. (2003). *Humanism of the Other* (Trans. N. Poller). Chicago: University of Illinois.
- Lewis, P. (2000). Realism, causality and the social structure. *Journal for the Theory of Social Behaviour*, 30(3), 249-268.
- Lewis, S. & Bor, R. (1998). How counselling psychologists are perceived by NHS clinical psychologists. *Counselling Psychology Quarterly*, 11(4), 427-437.
- Liebrucks, A. (2001). The concept of social construction. *Theory and Psychology*, 11(3), 363-391.
- Littlewood, R. (1991). Against pathology: The new psychiatry and its critics. *British Journal of Psychiatry*, 159(5), 696-702.
- Long, C.G. & Hollin, C.R. (1997). The scientist-practitioner model in clinical psychology: A critique. *Clinical Psychology and Psychotherapy*, 4(2), 75-83.

Lyddon, W.J. (1998). Social construction in counselling psychology: A commentary and critique. *Counselling Psychology Quarterly*, 11(2), 215-222.

Lynch, M. (2000). Against reflexivity as an academic virtue and source of privileged knowledge. *Theory, Culture and Society*, 17(3), 326-354.

Lysaker, P.H. & Lysaker, J.T. (2006). A typology of narrative impoverishment in schizophrenia: Implications for understanding the processes of establishing and sustaining dialogue in individual psychotherapy. *Counselling Psychology Quarterly*, 19(1), 57-68.

Lysaker, P.H., Davis, L.W., Jones, A.M., Strasburger, A.M. & Beattie, N.L. (2007). Relationship and technique in the long-term integrative psychotherapy of schizophrenia: A single case study. *Counselling and Psychotherapy Research*, 7(2), 79-85.

Lupton, D. (1992). Discourse analysis: A new methodology for understanding the ideologies of health and illness. *Australian Journal of Public Health*, 16(2), 145-150.

Madill, A. & Doherty, K. (1994). 'So you did what you wanted then': Discourse analysis, personal agency, and psychotherapy. *Journal of Community and Applied Social Psychology*, 4(4), 261-273.

Madill, A., Jordan, A. & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, 91(1), 1-20.

Magnavita, J.J. (2000). Introduction: The growth of relational therapy. *Journal of Clinical Psychology*, 56(8), 999-1004.

Mahrer, A.R. (2000). Philosophy of science and the foundations of psychotherapy. *American Psychologist*, 55(10), 1117-1125.

Manicas, P.T. & Secord, P.F. (1983). Implications for psychology of the new philosophy of science. *American Psychologist*, 38(4), 399-413.

Manning, K. (1997). Authenticity in constructivist inquiry: Methodological considerations without prescription. *Qualitative Inquiry*, 3(1), 93-115.

Mantzoukas, S. (2005). The inclusion of bias in reflective and reflexive research: A necessary prerequisite for securing validity. *Journal of Research in Nursing*, 10(3), 279-295.

Marshall, S. (2004). *Difference and Discrimination in Psychotherapy and Counselling*. London: Sage Publications.

Mather, R. (2000). The foundations of critical psychology. *History of the Human Sciences*, 13(2), 85-100.

Mauthner, N.S. & Doucet, A. (2003). Reflexive accounts and accounts of reflexivity in qualitative data analysis. *Sociology*, 37(3), 413-431.

- May, R. (2004). Making sense of psychotic experiences and working towards recovery. In: J. Gleeson & P. McGorry (Eds.), *Psychological Interventions in Early Psychosis: A Treatment Handbook*, pp.245-260. Chichester: John Wiley and Sons.
- May, R. (2007). Working outside the diagnostic frame. *The Psychologist*, 20(5), 300-301.
- McCabe, R., Saidi, M. & Priebe, S. (2007). Patient-reported outcomes in schizophrenia. *British Journal of Psychiatry*, 191(50), 21-28.
- McLaughlin, T. (1996). Coping with hearing voices: An emancipatory discourse analytic approach. *Changes: An International Journal of Psychology and Psychotherapy*, 14, 238-243.
- McLeod, J. (2003a). Qualitative research methods in counselling psychology. In: R. Woolfe, W. Dryden & S. Strawbridge (Eds.), *Handbook of Counselling Psychology (Second Edition)*, pp.74-92. London: Sage Publications.
- McLeod, J. (2003b). The humanistic paradigm. In: R. Woolfe, W. Dryden & S. Strawbridge (Eds.), *Handbook of Counselling Psychology (Second Edition)*, pp.140-160. London: Sage Publications.
- McNamee, S. & Gergern, K.J. (1992). *Therapy as Social Construction*. London: Sage Publications.
- Mills, C.E. & Pawson, K. (2006). Enterprising talk: A case of self construction. *International Journal of Entrepreneurial Behaviour and Research*, 12(6), 328-344.
- Milton, M. (1995). The development of counselling psychology in a clinical psychology service. *Counselling Psychology Quarterly*, 8(3), 243-247.
- Milton, M. (Ed.) (2003). Evidence-based practice. *Counselling Psychology Review*. 18(3), 3-35.
- Milton, M., Craven, M. & Coyle, A. (2010). Understanding human distress: Moving beyond the concept of 'psychopathology'. In: M. Milton (Ed.), *Therapy and Beyond: Counselling Psychology Contributions to Therapeutic and Social Issues*, pp.57-72. Chichester: Wiley-Blackwell.
- Misra, G. (1993). Psychology from a constructionist perspective: An interview with Kenneth J. Gergen. *New Ideas in Psychology*, 11(3), 399-414.
- Mitchell, P.F. (2009). A discourse analysis on how service providers in non-medical primary health and social care services understand their roles in mental health care. *Social Science and Medicine*, 68(7), 1213-1220.
- Morrison, A.P., Frame, L. & Larkin, W. (2003). Relationships between trauma and psychosis: A review and integration. *British Journal of Clinical Psychology*, 42(4), 331-353.

- Morrison, T. (1992). *Playing in the Dark: Whiteness and a Literary Imagination*. Cambridge, MA: Harvard University Press.
- Morrow, S.L. (2007). Qualitative research in counseling psychology: Conceptual foundations. *The Counseling Psychologist*, 35(2), 209-235.
- Morse, J.M. (2000). Determining sample size. *Qualitative Health Research*, 10(1), 3-5.
- Moussa, M. & Scapp, R. (1996). The practical theorizing of Michel Foucault: Politics and counter-discourse. *Cultural Critique*, 33(Spring), 87-112.
- Moynihan, R., Heath, I. & Henry, D. (2002). Selling sickness: The pharmaceutical industry and disease mongering. *British Medical Journal*, 324(7342), 886-890.
- Mullan, B. (1995). *Mad to Be Normal: Conversations with R.D. Laing*. London: Free Association Books.
- Mullen, P.E. (2007). A modest proposal for another phenomenological approach to psychopathology. *Schizophrenia Bulletin*, 33(1), 113-121.
- Munley, P. H., Duncan, L. E., McDonnell, K. A. & Sauer, E. M. (2004). Counseling psychology in the United States of America. *Counselling Psychology Quarterly*, 17(3), 247-271.
- National Institute for Clinical Excellence (2003). *Schizophrenia: Full National Clinical Guideline on Core Interventions in Primary and Secondary Care*. London: Gaskell, Leicester: The British Psychological Society.
- National Institute for Clinical Excellence (2009). *Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Adults in Primary and Secondary Care*. London: Gaskell, Leicester: The British Psychological Society.
- Ng, R.M.K., Pearson, V., Lam, M., Law, C.W., Chiu, C.P.Y. & Chen, E.Y.H. (2008). What does recovery from schizophrenia mean? Perceptions of long-term patients. *International Journal of Social Psychiatry*, 54(2), 118-130.
- Nicolson, P. (1995). Qualitative research, psychology and mental health: analysing subjectivity. *Journal of Mental Health*, 4(4), 337-346.
- Nightingale, D.J. (2004). Depression: Embodying social inequality. *Journal of Critical Psychology, Counselling and Psychotherapy*, 4(3), 176-187.
- Nightingale, D.J. & Cromby, J. (Eds.) (1999). *Social Constructionist Psychology: A Critical Analysis of Theory and Practice*. Buckingham: Open University Press.
- Nightingale, D.J. & Cromby, J. (2002). Social constructionism as ontology: Exposition and example. *Theory and Psychology*, 12(5), 701-713.

Nightingale, D.J. & Neilands, T. (1997). Understanding and practicing critical psychology. In: D. Fox, & I. Prilleltensky (Eds.), *Critical Psychology: An Introduction*, pp.68-84. London: Sage Publications.

Nikander, P. (2008). Constructionism and discourse analysis. In: J.A. Holstein & J.F. Gubrium (Eds.), *Handbook of Constructionist Research*, pp.413-428. New York: Guilford Press.

Nofsinger, R.E. (1991). *Everyday Conversation*. Thousand Oaks, CA: Sage Publications.

Orlans, V. & van Scoyoc, S. (2009). *A Short Introduction to Counselling Psychology*. London: Sage Publications.

Osborne, J. & Coyle, A. (2002). Can parental responses to adult children with schizophrenia be conceptualized in terms of loss and grief? A case study analysis. *Counselling Psychology Quarterly*, 15(4), 307-323.

Owen, I. (1992). The tower of Babel: Searching for core clinical, theoretical and ethical issues in psychotherapy. *Counselling Psychology Quarterly*, 5(1), 67-78.

Owen, I. (1995). El construccionismo social y la teoria, practica e investigacion en psicoterapia: Un manifiesto psicologia fenomenologica (Social constructionism and the theory, practice and research of psychotherapy: A phenomenological psychology manifesto, Trans. I. Caro). *Boletin de Psicologia*, 46, 161-186.

Paley, G. & Shapiro, D.A. (2002). Lessons from psychotherapy research for psychological interventions for people with schizophrenia. *Psychology and Psychotherapy: Theory, Research and Practice*, 75(1), 5-17.

Parker, I. (1992). *Discourse Dynamics: Critical Analysis for Social and Individual Psychology*. London: Routledge.

Parker, I. (1994). Reflexive research and the grounding of analysis: Social psychology and the psy-complex. *Journal of Community and Applied Social Psychology*, 4(4), 239-252.

Parker, I. (1996). Against Wittgenstein: Materialist reflections on language in psychology. *Theory and Psychology*, 6(3), 363-384.

Parker, I. (1997). Discursive psychology. In: D. Fox & I. Prilleltensky (Eds.), *Critical Psychology: An Introduction*, pp.284-298. London: Sage Publications.

Parker, I. (1999a). Critical reflexive humanism and critical constructionist psychology. In: D.J. Nightingale & J. Cromby (Eds.), *Social Constructionist Psychology: A Critical Analysis of Theory and Practice*, pp.23-36. Buckingham: Open University Press.

Parker, I. (1999b). Against relativism in psychology, on balance. *History of the Human Sciences*, 12(4), 61-78.

- Parker, I. (1999c). Deconstructing diagnosis: Psychopathological practice. In: C. Feltham (Ed.), *Controversies in Psychotherapy and Counselling*, pp.104-112. London: Sage Publications.
- Parker, I. (1999d) (Ed.). *Deconstructing Psychotherapy*. London: Sage Publications.
- Parker, I. (2002). Universities are not a good place for counselling and psychotherapy training. *European Journal of Psychotherapy, Counselling and Health*, 5(4), 331-346.
- Parker, I. (2004). Discursive practice: Analysis, context and action in critical research. *International Journal of Critical Psychology*, 10, 150-173.
- Parker, I. (2007). Critical psychology: What it is and what it is not. *Social and Personality Psychology Compass*, 1(1), 1-15.
- Parker, I. & Burman, E. (1993). Against discursive imperialism, empiricism and constructionism: Thirty-two problems with discourse analysis. In: E. Burman & I. Parker (Eds.), *Discourse Analytic Research: Repertoires and Readings of Texts in Action*, pp.155-172. London: Routledge.
- Parker, I., Georgaca, E., Harper, D., McLaughlin, T., & Stowell-Smith, M. (1995). *Deconstructing Psychopathology*. London: Sage Publications.
- Parkinson, B. (1995). *Ideas and Realities of Emotion*. London: Routledge.
- Parry, G. (2000). Evidence based psychotherapy: Special case or special pleading? *Evidence Based Mental Health*, 3, 35-37.
- Pelling, N. (2004). Counselling psychology: Diversity and commonalities across the Western World. *Counselling Psychology Quarterly*, 17(3), 239-245.
- Pérez-Álvarez, M. & García-Montes, J.M. (2007). The Charcot effect: The invention of mental illness. *Journal of Constructivist Psychology*, 20(4), 309-336.
- Perry, K.L. (2007). Constructing (dis)order: A discourse analysis of constructions of 'personality disorder' in British clinical psychology literature, Vol. 1. *Theses from the University of Surrey, Paper 79*.
- Petersen, C.A. (2007). A historical look at psychology and the scientist-practitioner model. *American Behavioral Scientist*, 50(6), 758-765.
- Pilgrim, D. & Treacher, A. (1992). *Clinical Psychology Observed*. London: Routledge.
- Pilgrim, D. (2000). Psychiatric diagnosis: More questions than answers. *The Psychologist*, 13(6), 302-305.
- Pilgrim, D. (2007). The survival of psychiatric diagnosis. *Social Science and Medicine*, 65(3), 536-547.

- Polkinghorne, D.E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology*, 52(2), 137-145.
- Pomerantz, A. (1986). Extreme case formulations: A way of legitimizing claims. *Human Studies*, 9(2-3), 219-229.
- Ponterotto, J.G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, 52(2), 126-136.
- Ponterotto, J.G. & Grieger, I. (2007). Effectively communicating qualitative research. *The Counseling Psychologist*, 35(3), 404-430.
- Porter, R. (2003). *The Faber Book of Madness*. London: Faber and Faber.
- Potter, J. (1996). Discourse analysis and constructionist approaches: Theoretical background. In: J.T.E. Richardson (Ed.), *Handbook of Qualitative Research for Psychology and the Social Sciences*, pp.125-140. Leicester: BPS Books.
- Potter, J. (2002). Two kinds of natural. *Discourse Studies*, 4(4), 539-542.
- Potter, J. (2003). Discourse analysis. In: M. Hardy & A. Bryman (Eds.), *Handbook of Data Analysis*, pp.607-624. London: Sage Publications.
- Potter, J., Edwards, D. & Ashmore, M. (1999). Regulating criticism: Some comments on an argumentative complex. *History of the Human Sciences*, 12(4), 79-88.
- Potter, J. & Hepburn, A. (2005). Qualitative interviews in psychology: Problems and possibilities. *Qualitative Research in Psychology*, 2(4), 281-307.
- Potter, J. & Wetherell, M. (1987). *Discourse and Social Psychology: Beyond Attitudes and Behaviour*. London: Sage Publications.
- Potter, J. & Wetherell, M. (1995). Discourse analysis. In: J. Smith, R. Harré, & R. van Langenhove (Eds), *Rethinking Methods in Psychology*, pp.80-92. London: Sage Publications.
- Pratten, S. (2009). Critical realism and causality: Tracing the Aristotelian legacy. *Journal for the Theory of Social Behaviour*, 39(2), 189-218.
- Prilleltensky, I. & Nelson, G.B. (2002). *Doing Psychology Critically: Making a Difference in Diverse Settings*. London: Palgrave.
- Pugh, D. & Coyle, A. (2000). The construction of counselling psychology in Britain: A discourse analysis of counselling psychology texts. *Counselling Psychology Quarterly*, 13(1), 85-98.
- Pujol, J. & Montenegro, M. (1999). 'Discourse or materiality?' Impure alternatives for recurrent debates. In: D.J. Nightingale & J. Cromby (Eds.), *Social Constructionist Psychology: A Critical Analysis of Theory and Practice*, pp.83-96. Buckingham: Open University Press.

Raymond, G. (2003). Grammar and social organization: Yes/No type interrogatives and the structure of responding. *American Sociological Review*, 68(December), 939-967.

Read, J. (2004). Does 'schizophrenia' exist? Reliability and validity. In: J. Read, L.R. Moshier & R.P. Bentall (Eds.), *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia*, pp.43-56. Hove, East Sussex: Routledge.

Read, J., Moshier, L.R., & Bentall, R.P. (2004a). 'Schizophrenia' is not an illness. In: J. Read, L.R. Moshier & R.P. Bentall (Eds.), *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia*, pp.3-8. Hove, East Sussex: Routledge.

Read, J., Goodman, L., Morrison, A.P., Ross, C.A. & Aderhold, V. (2004b). Childhood trauma, loss and stress. In: J. Read, L.R. Moshier & R.P. Bentall (Eds.), *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia*, pp.223-252. Hove, East Sussex: Routledge.

Read, J., Haslam, N., Sayce, L. & Davies, E. (2006). Prejudice and schizophrenia: A review of the 'mental illness is an illness like any other' approach. *Acta Psychiatrica Scandinavica*, 114(5), 303-318.

Regier, D.A., First, M., Marshall, T. & Narrow, T.E. (2002). The American Psychiatric Association (APA) classification of mental disorders: Strengths, limitations and future perspectives. In: M. Maj, W. Gaebel, J.J. López-Ibor & N. Sartorius (Eds.), *Psychiatric Diagnosis and Classification*, pp.47-78. New York: John Wiley and Sons.

Rennie, D. (1994). Human science and counselling psychology: Closing the gap between research and practice. *Counselling Psychology Quarterly*, 7(3), 235-250.

Repper, J. (2002). The helping relationship. In: N. Harris, S. Williams & T. Bradshaw (Eds.), *Psychosocial Interventions for People with Schizophrenia*, pp.39-52. Hampshire: Palgrave.

Richards, G. (2002). *Putting Psychology in its Place: A Critical Historical Overview (Second Edition)*. Hove: Routledge.

Richards, H.M. & Schwartz, L.J. (2002). Ethics of qualitative research: Are there special issues for health services research? *Family Practice*, 19(2), 135-139.

Riley, S.C.E. (2002). Constructions of equality and discrimination in professional men's talk. *British Journal of Social Psychology*, 41(3), 443-461.

Riley, S.C.E. (2003). The Management of the Traditional Male Role: A discourse analysis of the constructions and functions of provision. *Journal of Gender Studies*, 12(2), 99-113.

Rizq, R. (2006). Training and disillusion in Counselling Psychology: A psychoanalytic perspective. *Psychology and Psychotherapy: Theory, Research and Practice*, 79(4), 613-627.

Rizq, R. (2007). Tread softly: Counselling psychology and neuroscience. *Counselling Psychology Review*, 22(4), 5-18.

Rizq, R. (2008). Psychoanalysis revisited: A psychologist's view. *Counselling Psychology Review*, 23(1), 6-19.

Roberts, G. & Wolfson, P. (2004). The rediscovery of recovery: Open to all. *Advances in Psychiatric Treatment*, 10, 37-49.

Romme, M. & Escher, S. (1993). *Accepting Voices*. London: Mind Publications.

Rose, N. (1990). Psychology as a "social" science. In: I. Parker & J. Shotter (Eds.), *Deconstructing Social Psychology*. London: Routledge.

Rosenhan, D. (1973). On being sane in insane places. *Science*, 179(70), 250-258.

Roth, A.D. & Parry, G. (1997). The implications of psychotherapy research for clinical practice and service development: Lessons and limitations. *Journal of Mental Health*, 6(4), 367-380.

Rothman, D.J. (1971). *The Discovery of the Asylum: Social Order and Disorder in the New Republic*. Boston, MA: Little Brown and Company.

Rulf, S. (2003). Phenomenological contributions on schizophrenia: A critical review and commentary on the literature between 1980-2000. *Journal of Phenomenological Psychology*, 34(1), 1-46.

Sacks, H. (1995). *Lectures on Conversation* (Ed. G. Jefferson). Oxford: Blackwell.
Sampson, E. E. (1993). Identity politics: Challenges to psychology's understandings. *American Psychologist*, 48(12), 1219-1230.

Samson, C. (1995). Madness and psychiatry. In: B.S. Turner (Ed.), *Medical Power and Social Knowledge (Second Edition)*, pp.55-83. London: Sage Publications.

Sampson, E.E. (1993). Identity politics: Challenges to psychology's understanding. *American Psychologist*, 48(12), 1219-1230.

Sass, L.A. (1992). Heidegger, schizophrenia and the ontological difference. *Philosophical Psychology*, 5(2), 109-132.

de Saussure, F. (1983). *Course in General Linguistics*. London: Duckworth.

Scheff, T. (1999). *Being Mentally Ill (Third Edition)*. Hawthorne, NY: Aldine de Gruyter.

Schegloff, E.A. (1968). Sequencing in conversational openings. *American Anthropologist*, 70(6), 1075-1095.

Schegloff, E.A. (1997). Whose text? Whose context? *Discourse and Society*, 8(2), 165-187.

Seay, T.A. (2010). Counselling psychology: The Fifth Estate of Hong Kong mental health services. *Asia Pacific Journal of Counselling and Psychotherapy*, 1(1), 67-76.

Sequeira, H. & van Scoyoc, S. (2002). Division Round Table 2001: Should counselling psychologists oppose the use of DSM-IV and testing? *Counselling Psychology Review*, 16(4), 44-48.

Servais, L.M. & Saunders, S.M. (2007). Clinical psychologists' perceptions of persons with mental illness. *Professional Psychology: Research and Practice*, 38(2), 214-219.

Sherrard, C. (1991). Developing discourse analysis. *The Journal of General Psychology*, 118(2), 171-179.

Siirala, M.O. (1961). *Die Schizophrenie des Einzelnen und Der Allgemeinheit*. Göttingen: Wanderhoeck and Ruprecht.

Sims-Schouten, W., Riley, S.C.E. & Willig, C. (2007). Critical realism in discourse analysis: A presentation of a systematic method of analysis using women's talk of motherhood, childcare and female employment as an example. *Theory and Psychology*, 17(1), 101-124.

Sitz, L. (2008). Beyond semiotics and hermeneutics: Discourse analysis as a way to interpret consumers' discourses and experiences. *Qualitative Market Research: An International Journal*, 11(2), 177-191.

Skovholt, T. & Rønnestad, M. (2003). Struggles of the novice counselor and therapist. *Journal of Career Development*, 30(1), 45-58.

Smith, J.A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 1(1), 39-54.

Smith, J.A. & Osborn, M. (2003). Interpretative phenomenological analysis. In: J.A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods*, pp.51-80. London: Sage Publications.

Speer, S.A. (2002). 'Natural' and 'contrived' data: A sustainable distinction? *Discourse Studies*, 4(4), 511-525.

Speer, S.A. (2007). On recruiting conversation analysis for critical realist purposes. *Theory and Psychology*, 17(1), 125-135.

Spinelli, E. (2001). Counselling psychology: A hesitant hybrid or a tantalising innovation? *Counselling Psychology Review*, 16(3), 3-12.

Stainton Rogers, W. (1991). *Explaining Health and Illness: An Exploration of Diversity*. London: Harvester Wheatsheaf.

Stainton Rogers, W. (2009). Research methodology. In: D. Fox, I. Prilleltensky & S. Austin (Eds.), *Critical Psychology: An Introduction (Second Edition)*, pp.335-354. London: Sage Publications.

Stanley, P. & Manthei, R. (2004). Counselling psychology in New Zealand: The quest for identity for identity and recognition. *Counselling Psychology Quarterly*, 17(3), 301-315.

Starks, H. & Brown Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, 17(10), 1372-1380.

Steedman, P.H. (1991). On the relations between seeing, interpreting and knowing. In: F. Steier (Ed.), *Research and Reflexivity*, pp.53-62. London: Sage Publications.

Stenner, P. (1993). Discoursing jealousy. In: E. Burman & I. Parker (Eds.), *Discourse Analytic Research: Repertoires and Readings of Texts in Action*, pp.114-132. London: Routledge.

Stevens, P. & Harper, D.J. (2007). Professional accounts of electroconvulsive therapy: A discourse analysis. *Social Science and Medicine*, 64(7), 1475-1486.

Strauss, J.S. (1989). Subjective experiences of schizophrenia: Toward a new dynamic psychiatry-II. *Schizophrenia Bulletin*, 15(2), 179-187.

Strawbridge, S. (2006). Thoughts on becoming, being and developing as a Counselling Psychologist. *Counselling Psychology Review*, 21(1), 27-30.

Strawbridge, S. & James, P. (2001). Issues relating to the use of psychiatric diagnostic categories in counselling psychology, counselling and psychotherapy: What do you think? *Counselling Psychology Review*, 16(1), 4-6.

Strawbridge, S. & Woolfe, R. (1996). Counselling psychology: A sociological perspective. In: R. Woolfe & W. Dryden (Eds.), *Handbook of Counselling Psychology*, pp.605-629. London: Sage Publications.

Strawbridge, S. & Woolfe, R. (2006). Counselling psychology in context. In: R. Woolfe, W. Dryden & S. Strawbridge, S. (Eds.), *Handbook of Counselling Psychology (Second Edition)*, pp.3-22. London: Sage Publications.

Strawbridge, S. & Woolfe, R. (2010). Counselling psychology: Origins, developments and challenges. In: R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden (Eds.), *Handbook of Counselling Psychology (Third Edition)*, pp.3-22. London: Sage Publications.

Stricker, G. (2003). Evidence-based practice: The wave of the past. *The Counseling Psychologist*, 31(5), 546-554.

Sullivan, H.S. (1962). *Schizophrenia as a Human Process*. New York: Norton.

Szasz, T. (1974). *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. New York: Harper and Row.

Taylor, M. & Loewenthal, D. (2001). Researching a client's experience of preconceptions of therapy: A discourse analysis. *Psychodynamic Counselling*, 7(1), 63-82.

Teo, T. (2009). Philosophical concerns in critical psychology. In: D. Fox, I. Prilleltensky & S. Austin (Eds.), *Critical Psychology: An Introduction (Second Edition)*, pp.36-53. London: Sage Publications.

Thomas, P. & Bracken, P. (2004). Critical psychiatry in practice. *Advances in Psychiatric Treatment*, 10(5), 361-370.

Thompson, J.B. (1988). Mass communication and modern culture: Contribution to a critical theory of ideology. *Sociology*, 22(3), 359-383.

Tillich, P. (1988). *The Spiritual Situation in our Technical Society*. Atlanta: Mercer University Press.

Titone, D. (2010). Language, communication and schizophrenia. *Journal of Neurolinguistics*, 23(2), 173-175.

Torrey, E.F. (2006). *Surviving Schizophrenia: A Manual for Families, Patients and Providers (Fifth Edition)*. New York: Harper Collins.

Towns, A.J. & Adams, P.J. (2009). Staying quiet or getting out: Some ideological dilemmas faced by women who experience violence from male partners. *British Journal of Social Psychology*, 48(4), 735-754.

Turner, B.S. (1995). *Medical Power and Social Knowledge (Second Edition)*. London: Sage Publications.

Turner-Young, L. (2003). Counselling psychology and diagnostic systems: Do they have a place in our philosophy? *Counselling Psychology Review*, 18(1), 53-55.

Turpin, G., Barley, V., Beail, N., Scaife, J., Slade, P., Smith, J.A. & Walsh, S. (1997). Standards for research projects and theses involving qualitative methods: Suggested guidelines for students and courses. *Clinical Psychology Forum*, 108, 3-7.

Üstün, T.B., Chatterji, S. & Andrews, G. (2002). International classifications and the diagnosis of mental disorders: Strengths, limitations and future perspectives. In: M. Maj, W. Gaebel, J.J. López-Ibor & N. Sartorius (Eds.), *Psychiatric Diagnosis and Classification*, pp.25-46. New York: John Wiley and Sons.

Vespia, K.M. & Sauer, E.M. (2006). Defining characteristic or unrealistic ideal: Historical and contemporary perspectives on scientist-practitioner training in counselling psychology. *Counselling Psychology Quarterly*, 19(3), 229-251.

Wahl, O.F. & Harman, C.R. (1989). Family views of stigma. *Schizophrenia Bulletin*, 15(1), 131-139.

Walsh, Y., Frankland, A. & Cross, M. (2004). Qualifying and working as a counselling psychologist in the United Kingdom. *Counselling Psychology Quarterly*, 17(3), 317-328.

- Walton, C. (2007). Doing discourse analysis. In: E. Lyons & A. Coyle (Eds.), *Analysing Qualitative Data in Psychology*, pp.117-130. London: Sage Publications.
- Walton, C., Coyle, A. & Lyons, E. (2004). Death and football: An analysis of men's talk about emotions. *British Journal of Social Psychology*, 43(3), 401-416.
- Wampold, B.E. (2001a). *The Great Psychotherapy Debate: Models, Methods, and Findings*. Mahwah, NJ: Lawrence Erlbaum.
- Wampold, B.E. (2001b). Contextualizing psychotherapy as a healing practice: Culture, history, and methods. *Applied and Preventive Psychology*, 10(2), 69-86.
- Wampold, B.E., Ahn, H. & Coleman, H.L.K. (2002). Medical model as metaphor: Old habits die hard. *Journal of Counseling Psychology*, 48(3), 268-273.
- Watanabe-Muraoka, A.M. (2007). A perspective on counseling psychology in Japan: Toward a lifespan approach. *Applied Psychology*, 56(1), 97-106.
- Wetherell, M. (1994). The knots of power and negotiation, blank and complex subjectivities: Commentary for the special issue. *Journal of Community and Applied Social Psychology*, 4(4), 305-308.
- Wetherell, M. (1998). Positioning and interpretative repertoires: Conversation analysis and post-structuralism in dialogue. *Discourse and Society*, 9(3), 387-412.
- Wetherell, M. (2001). Debates in discourse research. In: M. Wetherell, S. Taylor & S.J. Yates (Eds.), *Discourse Theory and Practice: A Reader*, pp.380-400. London: Sage Publications.
- Widdicombe, S. (1995). Identity, politics and talk: A case for the mundane and the everyday. In: S. Wilkinson & C. Kitzinger (Eds.), *Feminism and Discourse: Psychological Perspectives*, pp.106-127. London: Sage Publications.
- Wiggins, S. & Potter, J. (2008). Discursive psychology. In: C. Willig & W. Stainton Rogers (Eds.), *The Sage Handbook of Qualitative Research in Psychology*, pp. 72-89. London: Sage Publications.
- Wilkinson, S. (1988). The role of reflexivity in feminist psychology. *Women's Studies International Forum*, 11(5), 493-502.
- Williams, D.J. & Irving, J. A. (1996). Counselling psychology: A conflation of paradigms. *Counselling Psychology Review*, 11(2), 4-7.
- Willig, C. (1998). Social constructionism and revolutionary socialism: A contradiction in terms? In: I. Parker (Ed.), *Social Constructionism, Discourse and Realism*, pp.91-104. London: Sage Publications.
- Willig, C. (1999). Beyond appearances: A critical realist approach to social constructionist work. In: D.J. Nightingale & J. Cromby (Eds.), *Social Constructionist Psychology: A Critical Analysis of Theory and Practice*, pp.37-51. Buckingham: Open University Press.

- Willig, C. (2006). *Introducing Qualitative Research in Psychology: Adventures in Theory and Method*. Buckingham: Open University Press.
- Willig, C. (2007). Discourse analysis. In: J.A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods (Second Edition)*, pp.160-185. London: Sage Publications.
- Willig, C. (2009). *Introducing Qualitative Research in Psychology: Adventures in Theory and Method (Second Edition)*. Buckingham: Open University Press.
- Wittgenstein, L. (1963). *Philosophical Investigations (Trans. G.E.M. Anscombe)*. New York: Macmillan.
- Wittgenstein, L. (1975). *Remarques Philosophiques*. Paris: Editions Gallimard.
- Wood, L.A. & Kroger, R.O. (2000). *Doing Discourse Analysis: Methods for Studying Action in Talk and Text*. London: Sage Publications.
- Woolfe, R. (1990). Counselling psychology in Britain: An idea whose time has come. *The Psychologist*, 12, 531-553.
- Woolfe, R. (1996). Counselling psychology in Britain: Past, present and future. *Counselling Psychology Review*, 11(2), 7-18.
- Woolgar, S. & Pawluch, D. (1985). Ontological gerrymandering: The anatomy of social problems explanations. *Social Problems*, 32(3), 214-227.
- World Health Organization (1994). *International Statistical Classification of Diseases and Related Health Problems*. Geneva: WHO.
- Wylie, M.S. (1995). Diagnosis for dollars? *The Family Therapy Networker*, May/June, 23-34, 65-69.
- Yanchar, S.C. & Hill, J.R. (2003). What is psychology about? Toward an explicit ontology. *Journal of Humanistic Psychology*, 43(1), 11-32.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15(2), 215-228.
- Zachar, P. (2001). Psychiatric disorders are not natural kinds. *Philosophy, Psychiatry, and Psychology*, 7(3), 167-182.
- Zachar, P. (2003). The practical kinds model as a pragmatist theory of classification. *Philosophy, Psychiatry, and Psychology*, 9(3), 219-227.